A RAND NOTE

CHARACTERISTICS OF HEALTH INSURANCE COVERAGE: DESCRIPTIVE AND METHODOLOGICAL FINDINGS FROM THE HEALTH INSURANCE EXPERIMENT

M. Susan Marquis

August 1986

N-2503-HHS

Prepared for

The U.S. Department of Health and Human Services

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PREFACE

The RAND Health Insurance Experiment collected detailed data on the scope and breadth of insurance benefits held by the sample of individuals who participated in the study. This Note discusses the construction of measures of insurance generosity based on these data. Using the measures, it then presents a descriptive analysis of the health insurance coverage of persons under age 65. This information should be of interest to analysts and policymakers concerned with health financing policy.

The Note also develops a simple index, using a few key characteristics of the insurance plan, that explains much of the variation between plans in the constructed generosity measures. This result should be of interest to persons designing data collection for health services research, inasmuch as it suggests a set of proxy indicators of plan generosity that can be obtained at reasonable cost.

The Health Insurance Experiment is supported under a grant from the U.S. Department of Health and Human Services.

SUMMARY

Information about the generosity of health insurance coverage is essential for formulating health financing policy. This Note describes the insurance coverage held by individuals under age 65, based on data collected as part of the RAND Health Insurance Experiment (HIE). Details about policies were obtained from carriers and employers. A summary measure of generosity was based on the out-of-pocket payments that a covered person can expect to make in a year.

In the late 1970s, when these data were collected, about 86 percent of the population under age 65 had some protection against the cost of medical care. Seven percent of the population were covered by public insurance programs, and 79 percent held private coverage.

Almost all of the privately insured had comprehensive coverage for inpatient hospital care; on average, the insured can expect to pay only about 5 percent of the hospital bill out of pocket. Outpatient coverage is less comprehensive; the share of physicians' charges for ambulatory care that the insured can expect to pay is 36 percent.

There are notable differences between income groups in the degree of protection against medical expenses. The poor are more likely to be uninsured than higher income individuals; 30 percent of those in families whose income is in the lowest quartile of the income distribution lack protection under either private insurance or public programs, whereas only 4 percent of people in the highest quartile are uninsured. The poor insured under private plans have less generous protection, particularly for catastrophic expenditures, than do high income families. The difference is pronounced if adequacy of protection is defined relative to income.

Comparing the coverage held by those insured under group policies with coverage of those who purchase individual insurance provides some insights into the possible effects of proposals to eliminate the tax incentives for health insurance and to mandate that employers offer additional options. The comparison suggests that elimination of the tax subsidy is likely to encourage more employees to forgo benefits for

routine services such as dental care and physician office visits with less effect on coverage for higher risk services. But those insured by individual plans also tend to have less coverage for catastrophic expenses. It may be important to assure that employees receive adequate information under multiple consumer choice systems if policy reforms are to have the intended effects.

One problem often confronting health services researchers is the availability of adequate measures of insurance plan benefits. RAND's plan generosity measures utilized very detailed information about what a plan would pay for any medical service use. The data collection and reduction costs associated with this effort, however, would be formidable for many research projects. Regression analysis found that a few key characteristics of a plan explain about 70 percent of the variance between plans in the comprehensive generosity measures. This result suggests a simple set of proxy indicators of plan generosity that can be obtained at reasonable cost.

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I. INTRODUCTION

Problems of both over and underinsurance occupy policy discussions about the financing of health care. The tax-exempt status of employer paid health insurance premiums is believed to be a cause of overinsurance. When consumers can pay insurance premiums with tax-exempt dollars, they may be induced to purchase more insurance than if they paid in taxable income. More comprehensive insurance coverage, in turn, leads to increased expenditures on health care services. To contain escalating health care expenditures, therefore, many advocate changing the tax treatment of employer paid health insurance premiums and requiring employers to offer a greater number of alternative health plans, hoping to encourage employees to purchase less comprehensive insurance coverage.

Although some segments of the population may be overinsured, others are underinsured, including people who do not have either private or public insurance coverage, and also insured individuals who do not have adequate protection against the risk of catastrophic medical expenditures. The problem of underinsurance is likely to take on increasing importance with Medicaid cutbacks and the growing reluctance of hospitals to provide charity care as they face greater competition and tighter reimbursement limits from third-party payors.

Data about the uninsured and about the benefits held by the insured population are essential for understanding and addressing the problems of underinsurance and overinsurance. This Note describes the insurance coverage of the population under 65 years of age based on data collected as part of the RAND Health Insurance Experiment (HIE).

This Note also serves a methodological purpose. Accurate data about benefits are central in much health economics and health services research because variation among individuals in the amount of coverage is an important determinant of variation in health services use. However, health insurance contracts are complex and frequently include deductibles, coinsurance rates, internal limits (such as limits on the number of doctor visits), stop loss provisions (limits on the patient

out-of-pocket liability) and fee-schedule limits (such as limits on the per visit charge for a doctor visit). Often these provisions vary from medical service to medical service and with the level of medical expenditures. Patients usually cannot accurately report the details of their coverage (Marquis, 1983), and the data collection and data reduction costs associated with obtaining all the myriad details from the insurance carriers are formidable for many research projects. As a result, many studies have relied on imperfect proxy measures of the extent of coverage, such as whether the individual has any insurance. The biases resulting from using such proxy measures have been considered elsewhere (Newhouse, Phelps, and Marquis, 1980). The methodological contribution here is to examine whether a few key, easily measured characteristics of insurance policies can explain most of the variation between policies in the generosity of benefits.

Section II describes the consumer sample, the data collection instruments, and the construction of a summary measure of the generosity of insurance benefits. Section III describes the insurance coverage held by the consumer sample. The methodological findings are reported in Sec. IV. An appendix contains the coding form used to abstract information about the insurance plans.

II. METHODS

SAMPLE

The sample for this analysis includes 7437 individuals under age 65 in Dayton, Ohio; Seattle, Washington; Fitchburg, Massachusetts; Franklin County, Massachusetts; Charleston, South Carolina; and Georgetown County, South Carolina. These people were members of families that subsequently participated in the HIE, a social experiment in health care financing.[1]

The sample was representative of each site's population subject to a few deliberate exclusions. Excluded from the sample frame were: (1) people in families with incomes in excess of $56,000 (in 1983 dollars); those in families headed by persons over age 65, (3) the institutionalized, and (4) those in the military and their dependents. Major characteristics of this sample (averaged across all sites) did not differ markedly from the population under age 65 as a whole.

DATA COLLECTION

Information on the insurance coverage of individuals in the sample was obtained from employers and insurance carriers. During a baseline interview conducted before the experimental phase of the study, families were asked to name employers of each family member and to state the source of each health insurance policy covering any family member. Each employer or carrier named by families was contacted by mail and asked to verify that the family's reported coverage was in effect, to report any coverage that the family may have failed to mention, and to provide brochures or pamphlets that described the benefits of the plan in detail. The data collected describe the insurance coverage of the sample at the time of the baseline survey, which was conducted over the period 1974 to 1976 depending on the site.

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[1]This sample includes all non-aged members of a family at the time of a pre-experimental baseline interview. Because of family composition changes between the baseline interview and the time of enrollment, not all individuals in this sample were subsequently enrolled in the experiment. For details about the HIE, see Newhouse et al. (1981) or Brook et al. (1984).

Study staff abstracted details of the coverage outlined in the policy brochures obtained from the carriers and employers onto a uniform insurance abstraction coding form. The form indicated what services the plan covered and abstracted sufficient information to determine what the plan would pay for any medical service use. The form is reproduced in the appendix.

CONSTRUCTING A MEASURE OF THE GENEROSITY OF PLAN BENEFITS

The measure of the generosity of plan benefits used here is based on the out-of-pocket payments for medical care that an individual can expect to make in a year. At the beginning of the year, a person is uncertain about the future occurrence of illness and the amount of medical services that will be used. Determining out-of-pocket expenditures requires knowing the different amounts and types of services that might be used and the likelihood that each pattern of use will occur, as well as the specific provisions of a person's insurance policy.

This distribution of expected expenses was represented by the observed use of care by selected participants in the experimental phase of the HIE. Participants included those in the experiment in the second year in each site who were assigned to an experimental insurance plan that paid in full for hospital care but required patients to pay 95 percent of ambulatory care to a maximum of $150 per person ($450 per family) per year. This experimental plan approximates one with a $150 per year deductible for ambulatory care and was chosen because use of hospital and physician services on this experimental plan was quite comparable to national figures (Newhouse et al., 1982).

For each insurance plan held at the time of the baseline interview, we simulated what the plan would and would not pay for the medical and dental care of each person in the experimental subsample. Included in the measure are all inpatient hospital and physician services, outpatient physician and hospital services, mental health visits, tests and x-rays, prescription drugs, and all dental services.[2] All of these

[2]Routine hearing and vision care and services of nonphysicians, such as chiropractors, are excluded.

services were covered by the experimental plan, and the use of these services during the experiment was measured from claims submitted by participants. The utilization data contain sufficient detail to account for fee-schedule limits, internal limits, and variation in benefits among different services or across expenditure levels in simulating what each baseline policy would reimburse. For a particular policy, the simulated amount of each patient's liability was averaged over everyone in the experimental subsample to measure the expected out-of-pocket expenditures for any person covered by that plan. The method assumes that the distribution of expected total medical care expenses for all persons is represented by the actual expenditure of those in the experimental sample. For each baseline insurance policy, separate estimates were made of the expected out-of-pocket liability for adults (18 or older) and children. Estimates of the adequacy of a plan's coverage for various risk classes were also estimated by averaging the simulated amount of the patient's liability for participants with expenditures in various quantiles of the distribution.[3]

We present estimates of the individual's expected level of out-of-pocket expenses and as a share of total expenses. The expected share of the bill is a measure of the average cost-sharing rate. For each plan, the average cost-sharing ratio was calculated as the ratio of simulated out-of-pocket expenditures for that plan, averaged over all participants, to the average total expenditure for all participants. This method yields a weighted average of the simulated cost-sharing rates for each person in the experimental subsample, where the weight is the share of total expenditures attributable to that individual. That is, the simulated cost-sharing rates for participants with above average expenditures receive a higher weight in the measure than the rates for those with below average expenditures.

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[3]A similar approach to measuring the generosity of coverage has been taken to compare insurance options available to federal employees (Francis, 1983) and to identify the extent of inadequate coverage based on data collected in the 1977 National Medical Care Expenditure Survey (Farley, 1985). These studies use stylized distributions based on various fractiles of the distribution and the average composition of expenditures within the expenditure interval.

III. PATTERNS OF HEALTH INSURANCE COVERAGE

INSURANCE STATUS

In the latter part of the 1970s, about 86 percent of the population under age 65 had some protection against the cost of medical care (Table 1).[1] Some 79 percent of the population held private insurance coverage, most of it through employer groups, and 7 percent had protection under public insurance programs. Among those insured under public programs, 10 percent also held private insurance coverage.

Insurance coverage varied considerably with demographic characteristics; young adults, nonwhites, and the poor were more likely to be uninsured than others. For example, among families whose income was in the lowest quartile of the distribution, less than half held private insurance coverage. Public insurance protected about 22 percent of the poor, but 30 percent of this group remained uninsured. By contrast, only 4 percent of individuals in high income families lacked insurance protection.

BENEFITS OF THE PRIVATELY INSURED

Almost all of the privately insured had coverage for inpatient hospital and physician services (Table 2).[2] Most of those with group coverage were also covered for such outpatient services as physician office visits and prescription drugs; however, this coverage was less common for people with individual insurance. Coverage for dental services was fairly uncommon.

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[1]These data are based on only the six HIE study sites, but the estimates of insurance status are comparable to national data for the same period (see Kasper, Walden, and Wilensky, 1980). More recent data also yield comparable estimates of the insurance status of the population (see Monheit et al., 1985).

[2]For data on the breadth of benefits based on the 1977 National Medical Care Expenditures Survey, see Farley, 1985; and Wilensky, Farley, and Taylor, 1984.

Table 1

INSURANCE COVERAGE BY TYPE AND SELECTED POPULATION CHARACTERISTICS
(Percent)

Population Characteristic	No Insurance	Type of Insurance Coverage		
		Public Insurance[a]	Private Insurance	
			Group[b]	Nongroup
All persons	14	7	72	7
Age in years				
Less than 18	14	11	69	6
18-24	26	7	60	7
25-34	13	4	78	5
35-44	9	4	80	7
45-64	10	2	75	13
Family income				
Lowest quartile	30	22	39	9
Second quartile	15	5	72	8
Third quartile	8	--	87	5
Highest quartile	4	--	89	7
Race				
White	12	5	76	7
Other	24	18	52	6

[a]Includes persons with both public and private coverage--about 1 percent of the total population.

[b]Includes persons with both group and nongroup coverage--about 2 percent of the total population.

-- Less than 0.5 percent.

The breadth of benefits for various services is illustrated in Table 3. Coverage was most comprehensive for inpatient hospital care; on average, the insured can expect to pay only about 5 percent of the hospital bill out of pocket. Outpatient coverage is much less comprehensive. The insured can expect to pay about 36 percent of outpatient physician and hospital charges, 43 percent of the cost of prescription drugs, and 45 percent of charges for outpatient mental health care. Overall, the privately insured's share of the cost of

medical care is about 20 percent, with insurance paying about 80 percent of the cost. For dental care, however, patients pay directly about 85 percent of the cost.

The primary purpose of insurance is to protect against uncertain, but potentially large, losses; and indeed the share of expenses paid out of pocket falls as the level of risk increases (Table 4). For medical expenses below the median, individuals assume more than half of the cost of care. The out-of-pocket share falls to 18 percent for medical expenses in the upper quartile of the distribution and to 14 percent for expenses in the upper decile. Given the recent trend for employers to modify their group coverage to increase the amount of the deductible and add stop loss provisions,[3] the relationship between the patient's share of the cost and the level of risk is probably somewhat more pronounced

Table 2

CHARACTERISTICS OF POLICIES HELD BY THOSE WITH PRIVATE INSURANCE COVERAGE
(Percent)

Policy Characteristics	All Persons	Group Coverage[a]	Nongroup Coverage
Type of policy			
HMO	7.7	8.4	--
Basic coverage only	12.5	7.2	71.0
Major medical only	8.2	8.6	4.0
Basic and major medical	71.4	75.8	22.7
Hospital Indemnity only	0.2	--	2.3
Scope of services covered			
Inpatient hospital	99.8	100.0	97.4
Inpatient physician	99.6	99.9	96.3
Physician office visits	90.4	93.1	59.9
Outpatient psychiatric visits	81.7	84.4	52.5
Prescription drugs	92.3	95.8	53.3
Dental	26.5	28.8	1.1

[a]About 3 percent of these also have a nongroup policy.
-- Less than 0.05 percent.

[3]*Washington Report on Medicine and Health*, August 20, 1984.

Table 3

EXPECTED OUT-OF-POCKET PAYMENTS BY THE PRIVATELY INSURED FOR VARIOUS MEDICAL AND DENTAL SERVICES

Type of Service	Expected Out-of-Pocket Payments (1982$)	Expected Payments as Percent of Expected Expense
Inpatient hospital	15.11	5.5
Inpatient physician	7.71	10.5
Outpatient physician and hospital	50.32	36.8
Outpatient psychiatric	26.18	45.0
Prescription drugs	19.96	43.3
Total medical care[a]	119.28	20.9
Dental care	145.77	84.8

[a]Includes physician office visits, outpatient surgery, outpatient hospital charges, outpatient diagnostic tests, and x-ray.

today than it was in the late 1970s, with patients assuming a greater share of the cost at low levels of risk and insurers paying a larger fraction of catastrophic expenses.

There are some differences in the adequacy of protection, particularly for catastrophic expenditures, among different population subgroups.[4] Nonwhites pay a larger share of the cost of medical bills than whites at all risk levels. Poor families have less generous protection for catastrophic illness than do high income families.

If adequacy of protection is defined relative to income, the differences in coverage between the poor and nonpoor become pronounced. Over half of insured people in the poorest families can expect out-of-pocket expenses in excess of 5 percent of family income if they

[4]Differences between children and adults in the expected out-of-pocket share at each level of medical expense is primarily attributable to differences in the mix of services. Outpatient preventive care, which is typically not covered by insurance, is a greater fraction of total medical expenditures for children than for adults; whereas hospital expenditures, which insurance covers in full, is a much smaller fraction of total medical expenditures for children.

Table 4

EXPECTED OUT-OF-POCKET PAYMENTS FOR MEDICAL CARE FOR THE PRIVATELY INSURED AT VARIOUS LEVELS OF RISK, BY SELECTED POPULATION CHARACTERISTICS
(Percent of expected expenditures)

Population Characteristic	Level of Medical Expense[a]			
	Below Median	Third Quartile	Top Quartile	Top Decile
All persons	69.8	54.2	18.3	14.4
Age in years				
Under 18	75.8	64.8	20.3	14.8
18-24	65.9	47.6	17.5	14.7
25-34	65.0	46.5	16.4	13.6
35-44	67.6	48.4	16.7	13.8
45-64	65.5	47.3	17.6	14.7
Family Income				
Lowest quartile	69.7	55.5	20.7	16.8
Second quartile	73.2	57.6	19.6	15.5
Third quartile	67.6	51.8	16.9	13.5
Highest quartile	69.0	53.2	17.5	13.2
Race				
White	68.6	52.7	17.9	14.2
Other	78.8	66.2	21.4	16.2

[a]Dental expenses are not included.

suffer catastrophic illness (defined as medical expenditures in the top decile of the distribution of expected expenses); one-fifth will have expenses in excess of 15 percent of income (Table 5). However, only 3 percent of individuals in high income families face out-of-pocket payments exceeding 5 percent of income if they have catastrophic illness.

Table 5

OUT-OF-POCKET PAYMENTS FOR MEDICAL CARE AS PERCENT OF FAMILY INCOME IF CATASTROPHIC ILLNESS[a] OCCURS
(Percent of persons)

	Percent of Family Income				
Family Income	Under 3	3-4	5-10	10 -14	15 or over
Lowest quartile	30	18	22	10	20
Second quartile	59	22	13	4	2
Third quartile	80	14	5	1	--
Highest quartile	89	8	2	1	--
All persons	70	15	9	3	3

[a]Defined as medical (nondental) expenses in the top 10 percent of the distribution.
-- Less than 0.5 percent.

GROUP INSURANCE VERSUS INDIVIDUAL INSURANCE

Comparing the coverage of those insured under group and individual policies may provide some insights into the possible effect of cost-containment proposals that seek to encourage shopping among health plans. The stratagems include eliminating the tax incentives for health insurance and mandating that employers offer additional options.

Currently, employers offer limited, if any, choice among plans. If additional coverage is mandated, private rather than group demand would characterize the market; therefore, the individual insurance market may inform us how coverage would adjust. The tax subsidy is also less important in the individual market[5] and loading fees typically higher than in group policies, so that market may indicate how purchase decisions would change if the price of insurance increased because the tax subsidy was eliminated.

[5]The direct deduction of $150 in premiums under the individual income tax, however, was still allowed at the time these data were collected.

As noted earlier, those who purchase individual insurance are less likely to obtain coverage for such routine but low cost services as outpatient physician visits than are those with group insurance; however, most insured individuals in both groups have coverage for services that have high expected costs, such as a hospitalization (Table 2). At the same time, those who purchase individual coverage have less protection against the risk of catastrophic expenses and shoulder a greater share of expenses for all services; the difference between those with individual insurance and those with group coverage in the share of the medical bill paid out of pocket increases with the level of risk (Table 6).

Table 6

EXPECTED OUT-OF-POCKET PAYMENTS BY TYPE OF PRIVATE INSURANCE
(Percent of expected expense)

Type of Service or Level of Medical Expense	Group Coverage[a]	Nongroup Coverage
Type of Service		
Inpatient hospital	4.1	18.7
Inpatient physician	8.7	28.6
Outpatient physician[b]	35.9	45.5
Outpatient psychiatrist	44.3	51.9
Prescription drugs	42.1	55.6
Dental care	83.5	99.4
Level of Medical Expenditures[c]		
Below median	70.8	58.5
Third quartile	54.4	52.2
Top quartile	17.1	31.0
Top decile	13.2	27.8

[a]About 3 percent of these individuals also have a nongroup policy.

[b]Includes physician office visits, outpatient surgery, outpatient hospital charges, outpatient diagnostic tests, and x-ray.

[c]Dental expenses not included.

Although many of the privately insured forgo coverage for routine outpatient services, those who do purchase this coverage tend to favor first-dollar benefits. This leads to the surprising finding that the average share of small medical bills paid out of pocket is less among those with individual coverage than among those with group coverage. For those with individual insurance, the average masks a great deal of heterogeneity--full coverage of routine expenses for some and no coverage for others. Most of those with group insurance have coverage that includes deductibles or coinsurance for outpatient services that make up the routine low cost medical bill.

Table 7 also shows the apparent preference among buyers of individual coverage to insure against more likely losses rather than the low probability, high risk loss. Although those with individual and group coverage are about equally likely to have first dollar coverage for hospital care, those with individual coverage purchase policies with lower maximum benefits than are held by those with group coverage. Those with nongroup coverage are more likely to purchase first dollar benefits for outpatient physician care. However, about 43 percent of those with group insurance have protection that limits their out-of-pocket expense, either as members of an HMO or through a stop loss provision, whereas only 4 percent of those with individual policies have such coverage.

Although differences in characteristics of those with group and individual coverage make firm generalizations difficult, differences in their insurance coverage do suggest the effects of mandated multiple choice and elimination of the tax subsidy. Based on the benefits purchased by those with individual coverage, who typically face higher prices or loading fees[6] than those with group coverage, elimination of the tax subsidy is likely to encourage more employees to forgo benefits for routine services such as dental care and physician office visits, with less effect on coverage for higher risk services.

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[6]The loading fee is the percent by which the premium exceeds the actuarial value of the policy.

Table 7

SELECTED BENEFITS BY GROUP OR NONGROUP COVERAGE
(Percent with benefit)

Type of Benefit	All Persons	Group Coverage	Nongroup Coverage
Hospital benefits			
Full coverage, maximum benefit less than 200 days or $20,000	12.0	10.1	32.8
Full coverage, maximum benefit greater than 200 days or $20,000	75.5	78.2	46.4
Some cost-sharing maximum benefit less than 200 days or $20,000	1.9	1.1	10.3
Some cost-sharing, maximum benefit greater than 200 days or $20,000	10.4	10.6	7.9
No hospital coverage	0.2	--	2.6
Physician office visit benefits			
Full coverage	16.1	14.1	38.8
Full coverage above deductible	6.2	6.6	1.1
Positive coinsurance	68.1	72.4	20.0
No outpatient physician coverage	9.6	6.9	40.1
Stop loss provision			
HMO plan	7.7	8.4	--
Major medical with stop loss provision	35.5	38.4	4.0
Major medical with no stop loss	44.1	46.0	22.7
Not covered by HMO or major medical	12.7	7.2	73.3

-- Less than 0.5 percent.

In choosing the breadth of coverage for various services, however, those purchasing individual coverage show a propensity to purchase first dollar protection rather than catastrophic protection. Some researchers have concluded that this propensity is due to difficulties people have in assessing probabilities and incorporating them into decisionmaking (Kunreuther, 1976). It may be difficult and costly for individuals to acquire sufficient information to assess the costs and benefits of each

option. The per person cost of acquiring information for a group may be much less, hence the group decisionmaker may be a more informed consumer. Group decisionmakers opt for cost-sharing for front-end expenses with catastrophic risk protection, a pattern of choice that policymakers would like to foster. If differences in the purchase patterns of groups and individuals reflect differences in information, it will be important to assure that employees receive adequate information under multiple consumer choice systems if policy reforms are to have the intended effects.

IV. A SIMPLE INDEX OF PLAN GENEROSITY

The plan generosity measures constructed utilized very detailed information about what a plan would pay for any medical service use. The data collection, coding, and reduction costs associated with this effort were considerable. This section regresses plan generosity measures on characteristics of the policy to investigate how well a few key characteristics of a plan capture the variation among plans in the generosity of benefits. Here the unit of analysis is the insurance policy; the generosity measures are the share of the medical bill the plan would reimburse at various risk levels.[1]

A limited set of characteristics about each plan was selected as the explanatory variables. The characteristics chosen describe the scope of benefits covered and some aspects of the depth of coverage for hospital and physician services, which constitute the bulk of medical expenditures. The explanatory variables include: an indicator for the type of policy; indicators for coverage of mental health visits, and those for prescription drugs; the deductible and coinsurance rate for hospital room and board; the deductible and coinsurance rate for physician office visits.[2] In preliminary analysis, variables were included that measure limits on hospital room and board benefits, major medical benefit limits, and stop loss provisions of major medical plans. Coefficients on these variables were not significantly different from zero and these variables are excluded in the regression results presented.

The means and standard deviations of the variables for the 529 policies included in the reported results are given in Table 8. Hospital indemnity only policies and policies covering only dental care

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[1]The generosity measures use the amount the plan would reimburse for the primary insured. Similar results obtained if we looked at the share the plan would pay for the spouse or dependents.

[2]If the coinsurance rate for hospital room and board or physician office visits varied with the level of expense, the first level coinsurance rate was used.

Table 8

MEANS AND STANDARD DEVIATIONS OF VARIABLES USED IN GENEROSITY MEASURE REGRESSIONS

Variable	Mean	Standard Deviation
Dependent		
Medical bill share reimbursed by expense level		
Below median	.27	.25
Third quartile	.42	.22
Top quartile	.75	.17
All expenses	.73	.17
Explanatory		
Type of policy[a]		
1 if HMO	.05	.21
1 if basic only	.14	.35
1 if major medical only	.13	.34
Indicator = 1 if mental health visits covered	.70	.46
Indicator = 1 if prescription drugs covered	.83	.37
Hospital room and board deductible	11.15	52.19
Outpatient visit deductible	59.58	65.31
Hospital room and board coinsurance[b]	.03	.11
Outpatient visit coinsurance[b]	.25	.30

[a]Omitted category is Major Medical and Basic.

[b]First level coinsurance if rate varies with level of expenditure.

or drug purchases were excluded from this analysis. Also excluded was one catastrophic plan that required an annual deductible of $5000. Examination of diagnostic statistics from models fitted including this policy indicated that the case was not well explained by the model but that it had considerable influence on the regression coefficients.[3] Because the $5000 deductible in this policy was so atypical, the policy was excluded in fitting the regressions shown in Table 9.

[3]As assessed using Cook's distance measure (Cook, 1977), which exceeded 1 for the case when it was included in the regressions.

Table 9

GENEROSITY MEASURE REGRESSIONS
(t-statistics in parentheses)

Explanatory Variable	Dependent Variable: Share of Bill Reimbursed for Various Levels of Medical Expenses			
	Below Median	Third Quartile	Top Quartile	All Expenses
Type of policy[a]				
1 if HMO	.554	.375	.078	.113
	(19.34)	(15.89)	(3.82)	(5.95)
1 if basic only	.102	.057	- .055	- .046
	(2.99)	(2.04)	(-2.33)	(-2.02)
1 if major medical only	- .141	-.056	-0.57	- .077
	(- 7.54)	(- 3.64)	(-4.40)	(-6.20)
Indicator = 1 if mental health visits covered	- .007	.027	.098	.089
	(- 0.46)	(2.12)	(9.22)	(8.79)
Indicator = 1 if prescription drugs covered	.007	.109	.126	.125
	(0.28)	(4.77)	(6.53)	(6.75)
Hospital room and board deductible/100	.001	.000	- .005	- .005
	(0.35)	(0.11)	(-2.54)	(-2.64)
Outpatient visit deductible/100	-0.137	- .157	- .034	- .030
	(-13.33)	(-18.52)	(-4.84)	(-4.33)
Hospital room and board coinsurance[b]	- .074	- .118	- .339	- .333
	(1.35)	(2.61)	(8.91)	(9.12)
Outpatient visit coinsurance[b]	- .405	- .327	- .133	- .124
	(12.72)	(12.46)	(6.03)	(-5.88)
Intercept	0.425	.472	.648	.624
R^2	.71	.74	.71	.71

[a]Omitted category is Major Medical and Basic.

[b]First level coinsurance if rate varies with level of expenditure.

Because expenditures for physician visits constitute the bulk of expenditures below median, it is not surprising that the physician office visit deductible and coinsurance are dominant in explaining plan generosity at this low risk level. The type of policy is also a significant determinant; basic plans and HMOs provide more extensive protection at low risk levels than major medical plans.

At higher risk levels, all of the key characteristics included in the regression are significantly related to plan generosity. Overall, the share of medical expenses reimbursed by insurance is 12.5 percentage points higher if the plan provides benefits for prescription drugs than if it does not, and 8.9 percentage points higher if it provides outpatient mental health benefits. Other things equal, a 10 percentage point increase in the coinsurance rate for physician office visits is associated with a 1.2 percentage point decrease in the share of the bill paid by the policy; a 10 percentage point increase in the room and board coinsurance rate reduces the reimbursed share by 3 percentage points. A $100 increase in the deductible for office visits and hospital room and board decreases the reimbursed share of the overall medical bill by 3 percentage points, or .5 percentage points, respectively. Plans that include both basic and major medical benefits cover a higher share of the bill than plans that include only basic or only major medical benefits but provide less extensive coverage than HMOs.

The most noteworthy result is that the seven key characteristics explain about 70 percent of the variance between plans in the detailed, comprehensive generosity measures that capture the many other dimensions on which plans vary. One problem often confronting health services researchers is the availability of adequate measures of insurance plan benefits. These results suggest a simple set of proxy indicators that can be obtained at reasonable cost.

Appendix

CODING FORM

The coding form used to abstract the detailed information about each insurance plan is reproduced in this appendix. Separate sections of the form pertain to the employer's medical reimbursement of employee out-of-pocket expenses, basic insurance coverage for hospital and medical care, major medical coverage for hospital and medical care, coverage of prescription drug purchases, dental care, vision care, hearing care, hospital indemnity coverage, and specified prolonged illnesses. Each of these sections contains a series of "screening questions" to determine the scope of services covered. Unless otherwise noted, screening questions are coded as "1" (Yes) or "2" (No). A "1" or "Yes" response requires the abstractor to answer all related subquestions that are vertically below and to the right of the screening question. The subquestions extract detail concerning limitations and restrictions.

The abstraction form also includes a section called Major Medical Schedules and one labeled General Benefits Schedule. The benefit provisions applicable to each covered service are coded on these schedules; the General Benefits Schedule is used for services covered by a basic benefit plan and the Major Medical Schedules for services covered by a major medical policy.

For each service covered by a basic benefits plan, one or more General Benefits Schedules are completed. Multiple schedules may be required if the coverage provisions change with the level of expenditures or length of time, or if different provisions apply to different family members. The number of schedules required to describe the benefits for a particular service is coded in the basic benefits section of the form to the right of the screening questions inquiring about coverage of the service. A three digit number assigned to each service is used to link completed general benefits schedules to the appropriate service.

At least one Major Medical Schedule is required for each major medical policy. The schedule describes the deductible, maximum, and percentage payable by the plan. If different provisions apply to different services or to different family members, multiple Major Medical Schedules are completed. Very rarely, the benefits of the major medical policy could not be adequately abstracted on a Major Medical Schedule. In these instances, a General Benefits Schedule was required in addition to a Major Medical Schedule. The applicable Major Medical Schedule and the number of General Benefits Schedules required for each covered service are coded next to the screening question for the service in the major medical section of the form.

ong Form

coder's initials

Cancer/dread disease only

Hospital Indemnity only

1/SDP#

11/ CARD 01

HIEI: 13/ 432

BOOKLET ID 22/ 3

28/ DATE CODED: Mon. Day. Year

GENERAL POLICY PROVISIONS

MEDICAL REIMBURSEMENT

1. Does the employer pay a portion of the employee's out-of-pocket health care costs after the insurance plan paid its portion? 36/ 2 - Go to Q2

What is paid by the employer? Complete the one answer which applies (A,B,C,D, or E).

A.
1. $ a per b months
2. $ a per calendar year
3. $ a per lifetime
4. $ a per spell of illness

37/ 1-4 a. b.

B.
1. a% to $ b per c months
2. a% to $ b per calendar year
3. a% to $ b per lifetime
4. a% to $ b per spell of illness
5. a% to no limit per c months
6. a% to no limit per calendar year
7. a% to no limit per lifetime
8. a% to no limit per spell of illness
9. a% to b% of employee's prior year's income

46/ 1-8 a. b. c.

C.
1. After $ a deductible, pays $ b per c months
2. After $ a deductible, pays $ b per calendar year
3. After $ a deductible, pays $ b per lifetime
4. After $ a deductible, pays $ b per spell of illness

58// 1-4 a. b. c.

D.
1. After $ a deductible, pays b% to $ c per d months (CARD 02)
2. After $ a deductible, pays b% to $ c per calendar year
3. After $ a deductible, pays b% to $ c per lifetime
4. After $ a deductible, pays b% to $ c per spell of illness
5. After $ a deductible, pays b% to no limit per d months
6. After $ a deductible, pays b% to no limit per calendar year
7. After $ a deductible, pays b% to no limit per lifetime
8. After $ a deductible, pays b% to no limit per spell of illness

13/ 1-8

14/ a. b. c. d.

E. None of the above. 29/

2. Does the booklet contain information concerning life insurance? 30/

CARD 03

CARRIER ID 13/ [5 | | | | | |]

BOOKLET ID 19/ [3 | | | | | |]

BASIC COVERAGE (HOSPITAL AND MEDICAL)

Does this plan include benefits for basic coverage? 37/ [ ]

ELIGIBILITY

1. Complete eligibility schedule
2. a. Does the plan have a coordination of benefits clause? 38/ [ ] P E G N
   b. Coordinates with which types of plan? (Write 1 or 2 in each box) 39/ [ ] [ ] [ ] [ ]

P = Private
E = Employer
G = Group
N = No fault auto insurance

A. INPATIENT ROOM AND BOARD (exclude maternity or psychiatric)

1. Are benefits provided for room and board in a short term general hospital? 43/ [ ] 1- 100 [ ] No. of Scheds.
2. Are the benefits for intensive care unit greater than for non-intensive room and board? 45/ [ ] 1- 101 [ ] No. of Scheds.
3. What benefit period limits are there? (See instruction 7 of General Benefits Schedule for values.) 47/ [ ] (1-6)
4. Do the benefits renew? (Answer if #3 is 1, 3 or 6]: Note: if employee and dependent renewal condition differ - answer for the employee.
   a. If out of the hospital for a specified number of days? 48/ [ ] 1- [ ] [ ] [ ] Days
   b. If return to work or be available for work for a specified number of days? 52/ [ ] 1- [ ] [ ] [ ] Days
   c. If accidental injury is incurred? 56/ [ ]
   d. If totally recovered from the illness or injury causing the confinement? 57/ [ ]

B. INPATIENT MISCELLANEOUS (exclude maternity or psychiatric).

1. Are benefits provided for inpatient miscellaneous? 58/ [ ]
2. Are miscellaneous benefits separate from room and board? 59/ [ ] 1- 102 [ ] No. of Scheds.
3. Does the policy/booklet provide benefits for either blood or blood plasma (not donated or replaced)? 61/ [ ] [1, 2, 3]
   a. Does the policy exclude reimbursement for some pints of blood? 62/ [ ] 1- [ ] No. of Pints

C. EXTENDED CARE FACILITY (skilled nursing)

1. Are benefits provided for ECF? 64/ ☐

2. Do the benefits for ECF differ from general inpatient benefits? 65/ ☐ 1- 103 ☐ No. of Scheds.

3. What benefit period limits are there? (See instruction 7 for values). 67/ ☐ (1-6)

4. Are some days of prior hospitalization required? 68/ ☐ 1- ☐☐ Days

5. Is there a limited number of days from hospital discharge to admit to ECF? 71/ ☐ 1- ☐☐ Days

6. Does one day in ECF reduce the hospital room and board maximum by a specified %? [If ½ day, code 50% etc.] 74/ ☐ 1- ☐☐☐ %

7. Does one dollar paid for ECF reduce the hospital room and board maximum by a specified dollar amount? 78// ☐ 1- ☐☐ Dollars

8. Is the maximum coverage for ECF stated as:

a. Number of days per specified number of months? (CARD 04) 13/ ☐ 1- ☐☐☐☐☐☐ Months

b. Amount of money per specified number of months? 20/ ☐ 1- ☐☐☐☐☐☐ Months

c. Number of days per lifetime? 28/ ☐ 1- ☐☐☐☐ Days

d. Amount of money per lifetime? 33/ ☐ 1- ☐☐☐☐☐☐ Dollars

D. OUTPATIENT HOSPITAL [exclude charges for physicians, x-rays and lab]. If benefits for all covered provisions are the same [other than the hours restrictions coded below], code schedule 186 only. Otherwise code a separate schedule for each question].

1. Are benefits provided for outpatient hospital treatment? 40/ ☐ 186 ☐ No. of Scheds.

2. Does coverage provide for the following?

a. All Accident? (with no time limits) 42/ ☐ 1- 104 ☐ No. of Scheds.

b. All Emergency? (with no time limits.) 44/ ☐ 1- 105 ☐ No. of Scheds.

c. Accidents for care provided within a specified number of hours? 46/ ☐ 1- ☐☐☐ hours 106 ☐ No. of Scheds.

d. Emergencies for care provided within a specified number of hours? 51/ ☐ 1- ☐☐☐ hours 107 ☐ No. of Scheds.

e. Accidents if initial care is provided within a specified number of hours? 56/ ☐ 1- ☐☐☐ hours 108 ☐ No. of Scheds.

f. Emergencies if initial care is provided within a specified number of hours? 61/ ☐ 1- ☐☐☐ hours 109 ☐ No. of Scheds.

g. Any Sickness? 66/ ☐ 1- 110 ☐ No. of

h. A life threatening non-accident emergency? 68/ ☐ 1- 111 ☐ No. of Scheds.

i. Facilities for any outpatient surgery? 70/ ☐ 1- 112 ☐ No. of Scheds.

j. Facilities for surgery only when it cannot be performed in a physician's office? 72// ☐ 1- 113 ☐ No. of Scheds.

(CARD 05)

k. Facility charges for radiation therapy or chemotherapy? 13/ ☐ 1- 114 ☐ No. of Scheds.

l. Facility charges for physical therapy? 15/ ☐ 1- 115 ☐ No. of Scheds.

m. Facility charges for dialysis? 17/ ☐ 1- 116 ☐ No. of Scheds.

CARD 03/04/05

E. SUPPLEMENTAL ACCIDENT EXPENSE

1. Are benefits provided for treatment of an accident under a supplemental [additional] accident expense benefit? 19/ 1-

117 No. of Scheds

1. a. Must all treatment be received within a specified number of days? 21/ 1-

No. of days

F. PHYSICIAN'S INPATIENT VISITS (exclude psychiatric or accident coverage)

1. Are benefits provided for inpatient physician's visits? 25/ 1-

118 No. of Scheds.

2. Are inpatient visits based on a fee schedule? 27/

a. Routine admission [90200] 28/

b. Routine visit [90250] 31/

3. Is there a service benefits provision? 33/

4. For service benefits to apply is the income limited:

a. to a set amount per individual? 34/ 1-

b. to a set amount per family? 41/ 1-

G. PHYSICIAN'S OUTPATIENT VISITS [exclude psychiatric, accident or minor surgery].

1. a. Are benefits provided for office visits? 1. Yes, any sickness 2. No 3. Medical emergency only. 48/ 1, 3- If 1 or 3, complete 1b.

119 No. of Scheds.

b. Is there a fee schedule for office visits? If yes, indicate the dollar amount for a routine office visit. [90050] 50/ 1-

2. a. Are benefits provided for home visits? 1. Yes, any sickness 2. No 3. Medical emergency only 53/ If 1 or 3, complete 2b&c.

b. Do benefits differ from routine office visits? 54/ 1-

120 No. of Scheds.

c. Is there a fee schedule for home visits? If yes, indicate the dollar amount for a routine home visit. [90150] 56/ 1-

3. a. Are benefits provided for outpatient hospital visits? 1. Yes, any sickness 2. No 3. Medical emergency only. 59/ If 1 or 3, complete 3b&c.

b. Do benefits differ from routine office visits? 60/ 1-

121 No. of Scheds.

c. Is there a fee schedule for O/P hospital visits? If yes, indicate the dollar amount for a routine O/P hospital visit. 62/ 1-

4. Are benefits provided for routine Physical Exams? 65/

5. Are benefits provided for Physical Therapy? 66/

a. Do the benefits differ from general physician's O/P visits? 67/ 1-

122 No. of Scheds.

b Is PT covered only when performed by a physician? 69/

c. Is PT covered when performed by a therapist only when referred by a physician? 70/

d. Is PT covered only when performed in an O/P Hospital Facility? 71/

CARD 05

6. Are benefits provided for Speech Therapy? 72/ ☐

   a. Do the benefits differ from general physician's O/P visits? 73/ ☐ 1- 123 ☐ No. of Scheds.

   b. Is speech therapy covered when performed by a licensed speech therapist only when referred by a physician? 75/ ☐

   c. Is speech therapy covered only if it is restoratory or rehabilitory and required because of an illness or following throat surgery? 76// ☐

7. Are benefits provided for Chiropractic care? (CARD 06) 13/ ☐

   a. Do the benefits differ from general physician's O/P visits? 14/ ☐ 1- 124 ☐ No. of Scheds.

   b. Are X-rays covered? 16/ ☐

   c. Are Office calls and treatment covered? 17/ ☐

   d. Is a Doctor of Chiropractic covered only when referred by a physician? 18/ ☐

   e. Does the plan cover certain procedures only if the problem is verified by X-Rays? 19/ ☐

8. Are benefits provided for Podiatric Care? 20/ ☐

   a. Do the benefits differ from general physician's O/P visits? 21/ ☐ 1- 125 ☐ No. of Scheds.

   b. Are all services performed by a DPM covered? 23/ ☐

   c. Are only services ordinarily performed by a physician covered? 24/ ☐

9. Are benefits provided for Acupuncture? 25/ ☐

   a. Do the benefits differ from general physician's O/P visits? 26/ ☐ 1- 126 ☐ No. of Scheds.

   b. Is acupuncture covered only when performed by a physician? 28/ ☐

10. Is there a common maximum for all outpatient visits? 29/ ☐ [1,2,3] If 2 or 3, skip to Q12.

11. Is the maximum:

			a.	b.	
a. A specified a. $(amount) per condition?	30/	☐ 1-	☐☐☐☐		
b. A specified a. (number) of visits per condition?	35/	☐ 1-	☐☐☐		
c. A specified a. $(amount) per b.(number) of months?	39/	☐ 1-	☐☐☐☐	☐☐	Mths.
d. A specified a. (number) of visits per b. (number) of months?	46/	☐ 1-	☐☐☐	☐☐	Mths.

12. Is there a service benefits provision? 52/ ☐

13. For service benefits to apply is the income limited to:

   a. A set amount per individual? 53/ ☐ 1- ☐☐☐☐☐☐

   b. A set amount per family? 60/ ☐ 1- ☐☐☐☐☐☐

H. SURGERY

1. Are surgical benefits provided? 67/ [ ] 1 - 2 or M - Go To I → 127 [ ] No. of Scheds. 69/ [ ]

2. a. Are benefits provided for the assistant surgeon?

   b. Is the assistant surgeon's benefit:

   1. Based on usual, customary and reasonable fees? 70/ [ ]
   2. Included in the flat allowance for the surgery? 71/ [ ]
   3. A percentage of the Assistant Surgeon's total fee? 72/ [ ] 1- [ ][ ] %
   4. A percentage of the surgeon's fee? 75 [ ] 1- [ ][ ] %
   5. A percentage of the allowance for surgery? 78// [ ] 1- [ ][ ] %

CARD 07

   6. Payable only when the allowance is above a specified amount? 13/ [ ] 1- [ ][ ][ ] Dollars
   7. Calculated in the same manner as surgeon's benefits? 17/ [ ]

3. Is there a fee schedule for surgery? If 1 or 3, complete Column A. If column A = 1 or 3, complete Column A1. 18/ [ ] 2 or M - Go to H4. →

		A. Cov'd?	A.1. Allowance	B. Anesthesia*	C. Time Factor*
a.	Mastectomy-simple unilateral (partial)? (19160)	19/ [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
b.	Tonsillectomy and adenoidectomy (T&A) (42840) under age 12.	32/ [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
c.	Appendectomy? (44950)	45/ [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
d.	Cholecystectomy (without common duct exploration)? (47600)	58// [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
e.	Inguinal hernia repair-unilateral? (49508)	CARD 08 13/ [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
f.	Vasectomy? (55250)	26/ [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
g.	Prostatectomy-perineal, subtotal? (55801)	39/ [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
h.	Diagnostic dilation and curettage (D&C)? (58120)	52/ [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
i.	Hysterectomy-total, abdominal? (58150)	65// [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
j.	Tubal ligation? (58982)	CARD 09 13/ [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
k.	Oophorectomy? (58940)	26/ [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]
l.	Laminectomy-lumbar? (63005)	39/ [ ] 1-	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]

* Refer to Question 6

CARD 06/07/08/09

4. Is Cosmetic Surgery covered: 52/

   a. For all family members , with no restrictions? 53/

   b. With no restrictions for children? 54/

   c. If accident related, with no other restrictions? 55/

   d. If accident related and only if the accident occurred while insured under the plan? 56/

   e. If needed as a result of a medically necessary surgery? 57/

   f. If needed to correct congenital anomalies in a child born while insured in the plan? 58/

5. Are benefits provided for the second surgical opinion? 59/

   a. Are second surgical opinions mandatory in order to receive benefits under the policy? 60/

6. a. Are benefits provided for the professional administration of anesthetics? 61/ 1- 128 No. of Scheds.

   b. Are benefits based on a fee schedule? If yes and col. A=1, complete the anesthesia column in #3B. 63/

   c. Are anesthesia benefits based on a time factor? (If yes indicate $ conversion per unit. If base amount for each surgery is indicated in dollars, write amounts in Col 3C. If base amount is indicated in units, multiply the base anesthesia units per unit each surgery by the conversion factor, and enter the product in column 3C). 64/ 1- Conversion per unit

   d. Must the anesthesia be administered by a physician? 68/

I. AMBULANCE (exclude maternity)

1. Are ambulance benefits provided? 69/ 1- 129 No. of Scheds.

2. Is transportation limited to local use? (within 50 miles) 71/

3. Must the patient be hospital confined? 72/

4. Must there have been an accident? 73/

5. Is there a limit to the number of trips per condition? 74/ 1- Trips

6. Is there a limit to the number of trips per condition per months? CARD 10 13/ 1- Trips Mths.

7. Are benefits payable only if the trip is made to or from a hospital? 18/

8. Are benefits payable only if the trip is made from the scene of illness or accident to the hospital where first treatment is given? 19/

CARD 09/10

J. PSYCHIATRIC

1. Are benefits provided for the diagnosis or treatment of psychiatric conditions? 20/ ☐ 2 or M - Go to N →
2. Are there maximums for psychiatric benefits? 21/ ☐ 2 or M - Go to K →

		1- Quantity	Per Mths	Lifetime limits
a.	Days for inpatient coverage.	22/		
b.	Money for inpatient coverage.	34/		
c.	Days for outpatient coverage.	48/		
d.	Money for outpatient coverage.	60/		
e.	Days for all psychiatric.	13/		
f.	Money for all psychiatric.	25/		

CARD 11

K. PSYCHIATRIC-INPATIENT HOSPITAL

1. Are benefits provided for inpatient hospital for psychiatric conditions? 39/ ☐ 2 or M - Go to L →
2. Does coverage provide for more than diagnosis and evaluation? 40/ ☐
3. Do these benefits differ from general inpatient benefits? 41/ ☐ 1- 130 ☐ No. of Scheds.
4. Are miscellaneous psychiatric services benefits separate from room and board for psychiatric services benefits? 43/ ☐ 1- 131 ☐ No. of Scheds.
5. What are the benefit period limits? (See instruction 7 of General Benefits Schedule for values). 45/ ☐ (1-6)
6. Do the benefits renew? (Answer if #5 = 1, 3 or 6] (Note: if employee and dependent renewal conditions differ, answer for the employee.) 46/ ☐
   a. If out of the hospital for a specified number of days? 47/ ☐ 1- ☐☐ Days
   b. If return to work or be available for work for a specified number of days? 50/ ☐ 1- ☐☐ Days
7. Are benefits provided for: [1, 2 or 3]
   a. Treatment in a short term general hospital? 53/ ☐
   b. Treatment in a Mental Health Institution? 54/ ☐
   c. Treatment of Alcoholism? 55/ ☐
   d. Treatment in a State-approved Alcoholism Facility? 56/ ☐
   e. Treatment of Drug-Addiction? 57/ ☐
   f. Treatment of Self-Inflicted injuries? 58/ ☐

L. PSYCHIATRIC-PHYSICIAN'S INPATIENT HOSPITAL VISITS

1. Are benefits provided for inpatient visits for psychiatric conditions? 59/ ☐
2. Does coverage provide for more than diagnosis and evaluation? 60/ ☐
3. Do these benefits differ from general I/P physician visits? (RVS 90807) 61/ ☐ 1- 132 ☐ No. of Scheds.
4. Is treatment by a psychologist as an independent practitioner covered? 63/ ☐
   a. Is treatment by a psychologist covered only under the supervision of a physician? 64/ ☐
5. Are benefits provided for:[1, 2 or 3]
   a. Treatment of Alcoholism? 65/ ☐
   b. Treatment of Drug-Addiction? 66/ ☐
   c. Treatment of Self-inflicted injuries? 67/ ☐
6. Is there a service benefits provision? 68/ ☐
7. For service benefits to apply, is the income limited to:
   a. A set amount per individual? 69// ☐ 1- ☐☐☐☐☐☐
   b. A set amount per family? CARD 12 13/ ☐ 1- ☐☐☐☐☐☐

M. PSYCHIATRIC-PHYSICIAN'S OUTPATIENT VISITS

1. Are benefits provided for O/P visits for psychiatric diagnosis? 20/ ☐ 2 or M - Go to N →
2. a. Do benefits for diagnostic psychiatric O/P visits differ from other O/P physician visits? 21/ ☐ 1- 133 ☐ No. of Scheds.
   b. Are benefits based on a fee schedule? If yes - indicate $ amount for initial diagnostic visit. (RVS 90010) 23/ ☐ 1- ☐☐☐ Dollars
3. Does coverage provide for more than diagnosis and evaluation? 27/ ☐ 2 or M - Go to M.6 →
4. a. Do benefits for Individual Therapy differ from other O/P physician's visits? 28/ ☐ 1- 134 ☐ No. of Scheds.
   b. Are benefits based on a fee schedule? If yes - indicate amount for a 30 minute individual session (RVS 90806) 30/ ☐ 1- ☐☐ Dollars
5. a. Are benefits provided for Group Therapy? 33/ ☐
   b. Are benefits for Group Therapy:
      1. Different than benefits for O/P physician visits? 34/ ☐ 2 or M - Go to M.6 →
      2. Different than benefits for O/P psychiatric individual therapy? 35/ ☐ 2 or M - Go to M.6 →
      3. If 1 and 2 are 1(yes), enter 1(yes) complete a GBS. 36/ ☐ 1- 135 ☐ No. of Scheds.
      4. Based on a fee schedule? If yes - indicate $ amount for a 45 min. group session (RVS 90821) 38/ ☐ ☐☐ Dollars

6. Is treatment by a psychologist as an independent practitioner covered? 41/ ☐

   a. Is treatment by a psychologist covered only under the supervision of a physician? 42/ ☐

7. Is treatment by a licensed clinical social worker covered as an independent practitioner? (Includes MSW) 43/ ☐

   a. Is treatment by a licensed clinical social worker covered only under the supervision of a physician? 44/ ☐

8. Are benefits provided for: [1, 2 or 3]

   a. Treatment of Alcoholism? 45/ ☐

   b. Treatment of Drug-Addiction? 46/ ☐

   c. Treatment of Self-inflicted injuries? 47/ ☐

9. Is there a service benefits provision? 48/ ☐

10. For service benefits to apply is the income limited to:

    a. A set amount per individual? 49/ ☐ 1- ☐☐☐☐☐☐

    b. A set amount per family? 56/ ☐ 1- ☐☐☐☐☐☐

N. OUTPATIENT DIAGNOSTIC, X-RAY AND LAB SERVICES (Exclude accident)

1. Are benefits provided for diagnostic x-ray and lab services? 63/ ☐ 1- 136 ☐ No. of Scheds.

2. Is there a fee schedule for diagnostic X-ray and lab services? (1,2,3) 65/ ☐ If 2 or M, skip to "O"
   If 1 or 3, complete a-h.

   a. Chest X-ray—PA? 66/ ☐ 1- ☐☐☐

   b. Electroencephalogram (EEG)? 70/ ☐ 1- ☐☐☐

   c. Gall bladder? 74// ☐ 1- ☐☐☐

CARD 13

   d. Brain scan? 13/ ☐ 1- ☐☐☐

   e. Urinalysis? 17/ ☐ 1- ☐☐☐

   f. Complete blood count (CBC)? 21/ ☐ 1- ☐☐☐

   g. Wasserman? (VDRL) 25/ ☐ 1- ☐☐☐

   h. Thyroid update (T3)? 29/ ☐ 1- ☐☐☐

O. PREGNANCY-RELATED BENEFITS [maternity, caesarean, abortion, miscarriage, tubal ligation vasectomy].

1. Are pregnancy-related benefits provided? 33/ ☐ 2 or M - Go to P →

2. Are benefits provided for complications of pregnancy? 34/ ☐

   a. Do benefits differ from regular illness? 35/ ☐

3. a. Are benefits provided for normal maternity care? 36/ ☐ 2 or M - Go to 010

   b. Eligibility requirements for normal delivery are as follows:

      1. Must deliver more than a specified number of months after coverage begins? 37/ ☐ 1- ☐☐ Months

      2. Must conceive while insured. 40/ ☐

      3. Must elect dependent coverage. 41/ ☐

      4. Must have family [2 party] coverage. 42/ ☐

      5. Must be insured or insured's wife. 43/ ☐

      6. Must be eligible under the plan at the time of delivery, regardless of eligibility at time of conception. 44/ ☐

4. Is there a deductible common to all normal maternity services? 45/ ☐ 1- ☐☐☐☐

5. Is there a maximum common to all normal maternity services? 50/ ☐ 1- ☐☐☐☐

6. Are inpatient hospital benefits provided for normal maternity care? 55/ ☐

7. Do benefits for maternity differ from general inpatient benefits? 56/ ☐ 1- 137 ☐ No. of Scheds.

8. Are inpatient miscellaneous benefits separate from room and board? 58/ ☐ 1- 138 ☐ No. of Scheds.

9. Are benefits provided for physician's delivery fee? 60/ ☐ 1- 139 ☐ No. of Scheds.

10. a. Are hospital nursery benefits provided for the well-born? (1,2,3) 62/ ☐

    b. Is there a deductible? If yes-indicate the deductible amount? 63/ ☐ 1- ☐☐☐

11. a. Are initial pediatrician benefits provided for the well born? (1,2,3) 67/ ☐

    b. Is there a deductible? (1,2,3) If (1), indicate the deductible amount. 68/ ☐ 1- ☐☐☐

CARD 14

12. Are benefits provided for Caesarean Hospitalization? 13/ ☐

    a. Are benefits the same as for maternity inpatient? 14/ ☐

    b. Are benefits the same as for regular I/P stay? 15/ ☐

    c. Are benefits the same as for regular I/P stay for a limited number of days? 16/ ☐ 1- ☐☐ Days

    d. Are benefits a specified sum of money? 19/ ☐ 1- ☐☐☐☐

13. Coverage of Physician's Services:

1. Same as regular surgery 2. Same as Normal Delivery 3. Special Maximum [enter $ amount] 4. Percent [enter amount] 5. None 6. Allowance included in Caesarean hospital allowance 7. Common Maximum: Hospital and Physician 8. Covered, but none of the above provisions apply.	Caesarean	24/ ☐	3 or 4-	☐☐☐
	"elective abortion"	28/ ☐	3 or 4-	☐☐☐
	Miscarriage	32/ ☐	3 or 4-	☐☐☐

P. GENERAL PROVISIONS

1. Are benefits provided for Home Health Care? 36/ ☐ 1- 140 ☐ No. of Scheds

   a. Are Basic benefits provided for home visits by a registered nurse (RN)? 38/ ☐

   b. Are Basic benefits provided for home visits by a licensed practical nurse (LPN?) 39/ ☐

   c. Are Basic benefits provided for home visits by a certified home health aide? 40/ ☐

   d. Are Basic benefits provided for home visits by interns and residents in training under an approved teaching program of a hospital with which the home health care agency is affiliated? 41/ ☐

   e. Are some days of prior hospitalization required? (1,2,3) 42/ ☐ 1,3- ☐☐☐ Days

   f. Are home health care visits limited to a specified number per week? 46/ ☐ 1- ☐☐ Visits

   g. Are home health care visits limited to a specified number per month? 49/ ☐ 1- ☐☐☐ Visits

   h. Are Basic benefits provided for home visits for physical therapy? 53/ ☐

   i. Are Basic benefits provided for home visits for respiration or inhalation therapy? 54/ ☐

2. Are benefits provided for Supplies/Durable Equipment? 55/ ☐ 1- 141 ☐ No. of Scheds.

COMMON MAXIMUM WORKSHEET

1. Are any of the following 6 services included in the hospital room and board dollar maximum? [Code 1, 2, M or N]

a.	Intensive care	57/	
b.	Miscellaneous inpatient services	58/	
c.	Extended care facility	59/	
d.	Psychiatric room and board	60/	
e.	Maternity room and board	61/	
f.	Inpatient physician	62/	

2. Are any of the following 4 services included in the inpatient miscellaneous dollar maximum?

a.	Outpatient hospital [exclude physician, X-ray and lab].	63/	
b.	Anesthesia	64/	
c.	Ambulance	65/	
d.	Blood	66//	

3. Are any of the following 14 services included in the physician office visit maximum?

CARD 15

a.	Inpatient physician visits	13/	
b.	Physician home visits	14/	
c.	Outpatient hospital physician visits	15/	
d.	X-ray and lab	16/	
e.	Outpatient surgery	17/	
f.	Physical therapy	18/	
g.	Speech therapy	19/	
h.	Psychiatric outpatient individual therapy	20/	
i.	Psychiatric outpatient group therapy	21/	
j.	Psychiatric inpatient physician visits	22/	
k.	Home Health	23/	
l.	Chiropractic care	24/	
m.	Podiatric care	25/	
n.	Acupuncture	26/	

4. Are any of the following 2 services included in the inpatient physician visits maximum?

a.	Inpatient surgery	27/	
b.	Psychiatric inpatient physician vists	28//	

Card 16 ›

CARRIER ID 13/ | 5 | | | | | |

BOOKLET ID 19/ | 3 | | | | | |

MAJOR MEDICAL

a. Does this plan include Major Medical coverage? 25/ ☐

b. Which type of major medical plan is this?
1. Comprehensive 2. Supplementary 26/ ☐ [1-2]

a. Is there a Basic Plan? 27/ ☐ 2- Complete Eligibility Schedule

b. Are Eligibility Requirements different from those for Basic Coverage? 28/ ☐ 1- Complete Eligibility Schedule

c. Does the plan have a coordination of benefits clause? 29/ ☐

d. Coordinates with which types of plan? [Write 1 or 2 in each box].

	P	E	G	N
30/				

P = Private
E = Employer
G = Group
N = No fault auto insurance

a. How long is the benefit period? In terms of months. 34/ ☐☐ Months

b. Does the benefit period apply:
1. To all disabilities?
2. To each disability? 36/ ☐ [1-2]

c. What provision is made for reinstatement of benefits? 37/ ☐☐ (1-12) ☐☐☐☐☐☐ Dollars

1. None. If 1, skip to A1.
2. Amount per year
3. Amount/disability
4. Amount/lifetime
5. Amount whenever used
6. All benefits/year
7. All benefits/disability
8. All benefits whenever used
9. Excess of $ amount/year
10. Excess of $ amount/disability
11. Excess of $ amount/lifetime
12. Excess of $ amount whenever used
13. All benefits/5 years.
14. Excess of $ amount whenever used; amount expressed in hundreds of dollars.
15. Other

d. Reinstatement occurs:
1. Automatically in full
2. Only upon evidence of insurability. 45/ ☐ [1-2]

CARD 16

A. INPATIENT ROOM AND BOARD [exclude maternity or psychiatric]

1. Are benefits provided for room and board in a short term general hospital?

2. Are the benefits for intensive care unit greater than for non-intensive room and board?

46/ ☐ 1-
50/ ☐ 1-

MM Sched. ☐☐

No. of Scheds. ☐ 142
☐ 143

B. INPATIENT MISCELLANEOUS [exclude maternity or psychiatric]

1. Are benefits provided for inpatient miscellaneous?

2. Does the policy/booklet provide benefits for either blood or blood plasma [not donated or replaced]?

   a. Does the policy exclude reimbursement for some pints of blood?

54/ ☐ 1-
58/ ☐ [1,2,3]
59/ ☐ 1-

MM Sched. ☐☐

No. of Scheds. ☐ 144

No. of pints ☐

C. EXTENDED CARE FACILITY [skilled nursing]

1. Are benefits provided for ECF?

2. Do the benefits for ECF differ from general inpatient benefits?

3. Are some days of prior hospitalization required?

4. Is there a limited no. of days from hospital discharge to admit to ECF?

5. Does one day in ECF reduce the hospital room and board maximum by a specified %? [If ½ day, code 50%, etc.]

6. Does one dollar paid for ECF reduce the hospital room and board maximum by a specified dollar amount?

7. Is the maximum coverage for ECF stated as:

   a. Number of days per specified number of months?

   b. Amount of money per specified number of months?

   c. Number of days per lifetime?

   d. Amount of money per lifetime?

61/ ☐
62/ ☐ 1-
66/ ☐ 1-
69/ ☐ 1-
72/ ☐ 1-
76// ☐ 1-

MM Sched. ☐☐
☐☐ Days
☐☐ Days
☐☐☐ %
☐☐ Dollars

No. of Scheds. ☐ 145

CARD 17

13/ ☐ 1- ☐☐☐☐☐☐ Mths.
20/ ☐ 1- ☐☐☐☐☐☐ Mths.
28/ ☐ 1- ☐☐☐☐ Days
33/ ☐ 1- ☐☐☐☐☐☐ Dollars

CARD 16/17

D. OUTPATIENT HOSPITAL [exclude charges for physicians, x-rays and lab]. If benefits for all covered provisions are the same [other than the hours restrictions coded below], code schedule 146 only. Otherwise code a separate schedule for each question].

			MM Scheds.	No. of Scheds.
1.	Are benefits provided for outpatient hospital treatment?	40/ [ ] 1-	[ ][ ]	[ ] 146
2.	Does coverage provide for the following?		MM Scheds.	No. of Scheds.
a.	All Accident? [with no time limits]	44/ [ ] 1-	[ ][ ]	[ ] 147
b.	All Emergency? [with no time limits]	48/ [ ] 1-	[ ][ ]	[ ] 148
c.	Accidents for care provided within a specified number of hours?	52/ [ ] [ ][ ][ ] hours	[ ][ ]	[ ] 149
d.	Emergencies for care provided within a specified number of hours?	59// [ ] 1- [ ][ ][ ] hours	[ ][ ]	[ ] 150
	CARD 18		MM Scheds.	No. of Scheds.
e.	Accidents if initial care is provided within a specified number of hours	13/ [ ] 1- [ ][ ][ ] hours	[ ][ ]	[ ] 151
f.	Emergencies if initial care is provided within a specified number of hours?	20/ [ ] 1- [ ][ ][ ] hours	[ ][ ]	[ ] 152
g.	Any Sickness?	27/ [ ] 1-	[ ][ ]	[ ] 153
h.	A life threatening non-accident emergency?	31/ [ ] 1-	[ ][ ]	[ ] 154
			MM Scheds.	No. of Scheds.
i.	Facilities for any outpatient surgery?	35/ [ ] 1-	[ ][ ]	[ ] 155
j.	Facilities for surgery only when it cannot be performed in physician's office?	39/ [ ] 1-	[ ][ ]	[ ] 156
			MM Scheds.	No. of Scheds.
k.	Facility charges for radiation therapy or chemotherapy.	43/ [ ] 1-	[ ][ ]	[ ] 157
l.	Facility charges for physical therapy	47/ [ ] 1-	[ ][ ]	[ ] 158
m.	Facility charges for dialysis.	51/ [ ] 1-	[ ][ ]	[ ] 159

E. SUPPLEMENTAL ACCIDENT EXPENSE

			MM Scheds.	No. of Scheds.
1.	Are benefits provided for treatment of an accident under a supplemental [additional] accident expense benefit?	55/ [ ] 1-	[ ][ ]	[ ] 160
1a.	Must all treatment be received within a specified number of days?	59/ [ ] 1- [ ][ ][ ] No. of days		

F. PHYSICIAN'S INPATIENT VISITS (exclude psychiatric or accident coverage).

MM Sched. No. of Scheds.

1. Are benefits provided for inpatient physician's visits? 63/ 1- 161
2. Are inpatient visits based on a fee schedule? 67/
   a. Routine Admission [90200] 68/ 1-
   b. Routine Visit [90250] 72// 1-

G. PHYSICIAN'S OUTPATIENT VISITS [exclude psychiatric, accident or minor surgery].

CARD 19

MM Sched No. of Scheds.

1. a. Are benefits provided for office visits? 13/ 1, 3- 162
   1. Yes, any sickness 2. No 3. Medical emergency only. If 1 or 3, complete 1b.
   b. Is there a fee schedule for office visits? If yes - indicate the dollar amount for a routine office visit [90050]. 17/ 1-
2. a. Are benefits provided for home visits? 20/ If 1 or 3, complete 2b&c MM Sched. No. of Scheds.
   1. Yes, any sickness 2. No 3. Medical emergency only.
   b. Do benefits differ from routine office visits? 21/ 1- 163
   c. Is there a fee schedule for home visits? If yes - indicate the dollar amount for a routine home visit. [90150] 25/ 1-
3. a. Are benefits provided for outpatient hospital visits? 28/ If 1 or 3, complete 3b&c. MM Sched No. of Scheds.
   1. Yes, any sickness 2. No. 3. Medical emergency only.
   b. Do benefits differ from routine office visits? 29/ 1- 164
   c. Is there a fee schedule for O/P hospital visits? If yes- indicate the dollar amount for a routine O/P hospital visit. 33/ 1-
4. Are benefits provided for routine Physical Exams? 36/
5. Are benefits provided for Physical Therapy? 37/

MM Sched No. of Scheds.

   a. Do the benefits differ from general physician's O/P visits? 38/ 1- 165
   b. Is PT covered only when performed by a physician? 42/
   c. Is PT covered when performed by a therapist, only when referred by a physician? 43/
   d. Is PT covered only when performed in an Outpatient Hospital Facility? 44/
   e. Is there a special max. a dollar amt. per b. no. of months? 45/ 1- a. b. Months
   f. Is there a special max. a. dollar amt. per lifetime? 52/ 1- Dollars
   g. Is there a special max. a. no. of visits per b. no. of months? 57/ 1- Months
   h. Is there a special max. a. no. of visits per lifetime? 63/ 1- Visits

CARD 18/19

6. Are benefits provided for Speech Therapy? 67/ ☐

MM Sched ☐☐ No. of Scheds. ☐ 166

a. Do the benefits differ from general physician's O/P visits? 68/ ☐ 1-

b. Is speech therapy covered when performed by a licensed speech therapist only when referred by a physician? 72/ ☐

c. Is speech therapy covered only if it is restoratory or rehabilitory and required because of an illness, accident, or following throat surgery? 73/ ☐

CARD 20

d. Is there a special max. a dollar amt. per b. no. of months? 13/ ☐ 1-

e. Is there a special max. a dollar amt. per lifetime? 20/ ☐ 1-

f. Is there a special max. a no. of visits per b. no. of months? 25/ ☐ 1-

g. Is there a special max. a. no. of visits per lifetime? 30/ ☐ 1-

	a.	b.	
d.	☐☐☐☐	☐☐	Months
e.	☐☐☐☐		Dollars
f.	☐☐	☐☐	Months
g.	☐☐☐		Visits

7. Are benefits provided for Chiropractic Care? 34/ ☐

MM Sched ☐☐ No. of Scheds. ☐ 167

a. Do the benefits differ from general physician's O/P visits? 35/ ☐ 1-

b. Are X-Rays covered? 39/ ☐

c. Are Office calls and treatment covered? 40/ ☐

d. Is a Doctor of Chiropractic covered only when referred by a physician? 41/ ☐

e. Does the plan cover certain procedures only if the problem is verified by X-Rays? 42/ ☐

f. Is there a special max. a dollar amt. per b. no. of months? 43/ ☐ 1-

g. Is there a special max. a dollar amt. per lifetime? 50/ ☐ 1-

h. Is there a special max. a. no. of visits per b. no. of months? 55/ ☐ 1-

i. Is there a special max. a. no. of visits per lifetime? 60/ ☐ 1-

	a.	b.	
f.	☐☐☐☐	☐☐	Months
g.	☐☐☐☐		Dollars
h.	☐☐	☐☐	Months
i.	☐☐☐		Visits

CARD 19/20

8. Are benefits provided for Podiatric care? 64/ ☐

MM Sched ☐☐ No. of Scheds. ☐ 163

a. Do the benefits differ from general physician/s O/P visits? 65/ ☐ 1-

b. Are all services performed by a DPM covered? 69/ ☐

c. Are only services ordinarily performed by a physician covered? 70/ ☐

d. Is there a special max. a dollar amt. per b. no. of months? 71// ☐ 1-

a. ☐☐☐☐ b. ☐☐ Mths.

CARD 21

e. Is there a special max. a dollar amt. per lifetime? 13/ ☐ 1- ☐☐☐☐ Dollars

f. Is there a special max. a. no. of visits per b. no. of months? 18/ ☐ 1- ☐☐☐☐ b. ☐☐ Mths.

g. Is there a special max. a. no. of visits per lifetime? 23/ ☐ 1- ☐☐☐ Visits

9. Are benefits provided for Acupuncture? 27/ ☐

MM Sched ☐ No. of Scheds. ☐ 169

a. Do the benefits differ from general physician's O/P visits? 28/ ☐ 1-

b. Is acupuncture covered only when performed by a physician? 32/ ☐

c. Is there a special max. a. dollar amt. per b. of months? 33/ ☐ 1-

d. Is there a special max.a.dollar amt. per lifetime? 40/ ☐ 1-

e. Is there a special max. a. no. of visits per b. no. of months? 45/ ☐ 1-

f. Is there a special max. a. no. of visits per.lifetime? 50/ ☐ 1-

a. ☐☐☐☐ b. ☐☐ Mths.

☐☐☐☐ Dollars

☐☐ b. ☐☐ Mths.

☐☐☐ Visits

4. SURGERY

1. Are surgical benefits provided? 54/ ☐ 2 or M - Go to 1; 1-

MM Sched ☐☐ No. of Scheds ☐ 170

2. a. Are benefits provided for the assistant surgeon? 58/ ☐

b. Is the assistant surgeon's benefit:

1. Based on usual, customary and reasonable fees? 59/ ☐

2. Included in the flat allowance for the surgery? 60/ ☐

3. A percentage of the Assistant Surgeon's total fee? 61/ ☐ 1- ☐☐ %

4. A percentage of the surgeon's fee? 64/ ☐ 1- ☐☐ %

5. A percentage of the allowance for surgery? 67/ ☐ 1- ☐☐ %

6. Payable only when the allowance is above a specified amount? 70/ ☐ 1- ☐☐☐ Dollars

7. Calculated in the same manner as the surgeon's benefits? 74// ☐

CARD 22

Is there a fee schedule for surgery? [1,2,3] If 1 or 3, complete Column A. If Column A = 1 or 3, complete Column A1.
1 = Yes 2 = No 3 = Yes, allowance varies with income.

13/ ☐ 2 or M - Go to QH4.

		A Cov'd?	A1. Allowance	B. Anesthesia*	C. Time Factor*
a.	Mastectomy unilateral (partial)?[19160]	14/ ☐	1,3-		
b.	Tonsillectomy and adenoidectomy [T&A] under age 12. [42840]	27/ ☐	1,3-		
c.	Appendectomy? [44950]	40/ ☐	1,3-		
d.	Cholecystectomy [without common duct exploration]? [47600]	53/ ☐	1,3-		
e.	Inguinal hernia repair-unilateral? [49508]	66// ☐	1,3-		

CARD 23

f.	Vasectomy? [55250]	13/ ☐	1,3-		
g.	Prostatectomy-perineal subtotal? [55801]	26/ ☐	1,3-		
h.	Diagnostic dilation and curettage [D&C]? [58120]	39/ ☐	1,3-		
i.	Hysterectomy-total, abdominal? [58150]	52/ ☐	1,3-		
j.	Tubal ligation? [58982]	65// ☐	1,3-		

CARD 24

k.	Oophorectomy? [58940]	13/ ☐	1,3-		
l.	Laminectomy-lumbar? [63005]	26/ ☐	1,3-		

*Refer to question 6

Is Cosmetic Surgery covered? 39/ ☐ ←

a.	For all family members, with no restrictions?	40/ ☐
b.	With no restrictions for children?	41/ ☐
c.	If accident related, with no other restrictions?	42/ ☐
d.	If accident related and only if the accident occurred while insured under the plan?	43/ ☐
e.	If needed as a result of a medically necessary surgery?	44/ ☐
f.	If needed to correct congenital anomalies in a child born while insured in the plan?	45/ ☐

5. Are benefits provided for second surgical opinion? 46/

   a. Are second surgical opinions mandatory? 47/

6. a. Are benefits provided for the professional administration of anesthetics? 48/ 1-

   b. Are benefits based on a fee schedule? If yes - complete the anesthesia column in #3B. 52/

   c. Are anesthesia benefits based on a time factor? If yes, indicate $ conversion per unit. If base amount for each surgery is indicated in dollars, write amounts in Col 3C. If base amount is indicated in units, multiply the base anesthesia units per unit each surgery by the conversion factor, and enter the product in column 3C]. 53/ 1-

   d. Must the anesthesia be administered by a physician? 57/

MM Sched. | No. of Scheds. 171

Conversion per unit

AMBULANCE [exclude maternity]

1. Are ambulance benefits provided? 58/ 1-
2. Is transportation limited to local use? [within 50 miles] 62/
3. Must the patient be hospital confined? 63/
4. Must there have been an accident? 64/
5. Is there a limit to the no. of trips per condition? 65/ 1-
6. Is there a limit to the no. of trips per condition per months? 68/ 1-
7. Are benefits payable only if the trip is made to or from a hospital? 73/
8. Are benefits payable only if the trip is made from the scene of illness or accident to the hospital where first treatment is given? 74/

MM Sched. | No. of Scheds. 172

Trips

Trips | Mths.

PSYCHIATRIC

1. Are benefits provided for the diagnosis or treatment of psychiatric conditions? 75/ 2 or M - Go to N →
2. Are there maximums for psychiatric benefits? 76// 2 or M - Go to K →

CARD 25

		Quantity	Per Mths.	Lifetime limits
a. Days for inpatient coverage.	13/ 1-			
b. Money for inpatient coverage.	23/ 1-			
c. Days for outpatient coverage.	37/ 1-			
d. Money for outpatient coverage.	46/ 1-			
e. Days for all psychiatric.	59// 1-			

CARD 26

f. Money for all psychiatric. 13/ 1-

K. PSYCHIATRIC-INPATIENT HOSPITAL

1. Are benefits provided for inpatient hospital for psychiatric conditions? 26/ ☐ 2 or M - Go to L

2. Does coverage provide for more than diagnosis and evaluation? 27/ ☐

3. Do these benefits differ from general inpatient benefits? 28/ ☐ I-

4. Are miscellaneous psychiatric services benefits separate from room and board for psychiatric services benefits? 32/ ☐ I-

	MM Sched	No. of Scheds.
	☐☐	☐ 173
	☐☐	☐ 174

5. Are benefits provided for: [1, 2 or 3]

a. Treatment in a short term general hospital? 36/ ☐

b. Treatment in a Mental Health Institution? 37/ ☐

c. Treatment of Alcoholism? 38/ ☐

d. Treatment in a State-approved Alcoholism Facility? 39/ ☐

e. Treatment of Drug-Addiction? 40/ ☐

f. Treatment of Self-inflicted injuries? 41/ ☐

L. PSYCHIATRIC-PHYSICIAN'S INPATIENT HOSPITAL VISITS

1. Are benefits provided for inpatient visits for psychiatric conditions? 42/ ☐

2. Does coverage provide for more than diagnosis and evaluation? 43/ ☐

3. Do these benefits differ from general inpatient physician visits? (RVS 90807) 44/ ☐ I-

	MM Sched	No. of Scheds.
	☐☐	☐ 175

4. Is treatment by a psychologist as an independent practitioner covered? 48/ ☐

a. Is treatment by a psychologist covered only under the supervision of a physician? 49/ ☐

5. Are benefits provided for: [1, 2 or 3]

a. Treatment of Alcoholism? 50/ ☐

b. Treatment of Drug-Addiction? 51/ ☐

c. Treatment of Self-inflicted injuries? 52/ ☐

CARD 26

PSYCHIATRIC-PHYSICIAN'S OUTPATIENT VISITS

1. Are benefits provided for outpatient visits for psychiatric diagnosis?

2. a. Do benefits for diagnostic psychiatric O/P visits differ from O/P physician's visits?

   b. Are benefits based on a fee schedule? [If yes - indicate $ amt. for initial diagnostic visit]. [RVS 90010]

3. Does coverage provide for more than diagnosis and evaluation?

4. a. Do benefits for Individual Therapy differ from other O/P physician visits?

   b. Are benefits based on a fee schedule? If yes - indicate $ amount for a 30 min. individual session. [RVS 90806]

5. a. Are benefits provided for Group Therapy?

   b. Are benefits for Group Therapy:

      1. Different than benefits for O/P physician visits?

      2. Different than benefits for O/P psychiatric individual therapy?

      3. If 1 and 2 are 1[yes], enter 1[yes] and complete schedule.

      4. Based on a fee schedule? If yes - indicate $ amount for a 45 min. group session [RVS 90821]

6. Is treatment by a psychologist as an independent practitioner covered?

   a. Is treatment by a psychologist covered only under the supervision of a physician?

7. Is treatment by a licensed clinical social worker covered as an independent practitioner? [Includes MSW]

   a. Is treatment by a licensed clinical social worker covered only under the supervision of a physician?

8. Are benefits provided for: [1, 2 or 3]

   a. Treatment of Alcoholism?

   b. Treatment of Drug-Addiction?

   c. Treatment of Self-inflicted injuries?

53/ ☐ 2 or M -Go to N — MM Sched ☐☐ — No. of Scheds. ☐ 176
54/ ☐ 1-
58/ ☐ 1- — ☐☐☐ Dollars

62/ ☐ 2 or M - Go to M6 ——
63/ ☐ 1- — MM Sched ☐☐ — No. of Scheds ☐ 177
67/ ☐ 1- — ☐☐☐ Dollars

70/ ☐

71/ ☐ 2 or M - Go to M6 ——

72/ ☐ 2 or M - Go to M6 ——
73/ ☐ 1- — MM Sched ☐☐ — No. of Scheds. ☐ 178
77// ☐ 1- — ☐☐☐ Dollars

CARD 27

13/ ☐ ←——

14/ ☐

15/ ☐

16/ ☐

17/ ☐
18/ ☐
19/ ☐

CARD 26/27

N. OUTPATIENT DIAGNOSTIC, X-RAY AND LAB SERVICES (Exclude accident)

MM Sched | No. of Scheds.

1. Are benefits provided for diagnostic x-ray and lab services? 20/ [ ] 1- If 2 or M, skip to "O" [ ][ ] [ ] 179

2. Is there a fee schedule for diagnostic X-ray and lab services? (1,2,3) If 1 or 3, complete a-h. 24/ [ ]
   1 = Yes 2 = No 3 = Yes, allowance varies with income.

a.	Chest X-ray--PA?	25/ [ ]	1,3- [ ][ ][ ]
b.	Electroencepnalogram [EEG]?	29/ [ ]	1,3- [ ][ ][ ]
c.	Gall bladder?	33/ [ ]	1,3- [ ][ ][ ]
d.	Brain scan?	37/ [ ]	1,3- [ ][ ][ ]
e.	Urinalysis?	41/ [ ]	1,3- [ ][ ][ ]
f.	Complete blood count [CBC]?	45/ [ ]	1,3- [ ][ ][ ]
g.	Wasserman? [VDRL]	49/ [ ]	1,3- [ ][ ][ ]
h.	Thyroid update [T3]?	53/ [ ]	1,3- [ ][ ][ ]

O. PREGNANCY-RELATED BENEFITS (maternity, caesarean, abortion, miscarriage, tubal ligation, vasectomy)

1. Are pregnancy-related benefits provided? 57/ [ ] 2 or M - Go to P ⟶
2. Are benefits provided for complications of pregnancy? 58/ [ ]
   a. Do benefits differ from regular illness? 59/ [ ]
3. a. Are benefits provided for normal maternity care? 60/ [ ] 2 or M - Go to O-10 ⟶
   b. Eligibility requirements for normal delivery are as follows:

1.	Must deliver more than a specified number of months after coverage begins.	61/ [ ]	1- [ ][ ] Months
2.	Must conceive while insured.	64/ [ ]	
3.	Must elect dependent coverage.	65/ [ ]	
4.	Must have family [2 party] coverage.	66/ [ ]	
5.	Must be insured or insured's wife.	67/ [ ]	
6.	Must be eligible under the plan at the time of delivery, regardless of eligibility at time of conception.	68/ [ ]	

4. Is there a deductible common to all normal maternity services? 69/ [ ] 1- [ ][ ][ ][ ]

CARD 28

5. Is there a maximum common to all normal maternity services? 13/ 1-

6. Are inpatient hospital benefits provided for normal maternity care? 18/

7. Do benefits for maternity differ from general inpatient benefits? 19/ 1-

8. Are inpatient miscellaneous benefits separate from room and board? 23/ 1-

MM Sched. No. of Scheds.
180
181

9. Are benefits provided for physician's delivery fee? 27/ 1-

MM Sched. No. of Scheds.
182

10. a. Are hospital nursery benefits provided for the well-born? (1,2,3) 31/
1 = Yes 2 = No 3 = Yes, included in mother's hospital benefits.
b. Is there a deductible? If yes-indicate the deductible amount. 32/ 1- Dollars

11. a. Are initial pediatrician benefits provided for the well-born? [1,2,3] 36/
1 = Yes 2 = No 3 = Yes, included in mother's physician's benefits.
b. Is there a deductible? [1,2,3] If [1], indicate the deductible amount. 37/ 1- Dollars
1 = Yes 2 = No 3 = Yes, common deductible coded in 10b.

12. Are benefits provided for Caesarean Hospitalization? 41/

a. Are benefits the same as for maternity inpatient? 42/

b. Are benefits the same as for regular I/P stay? 43/

c. Are benefits the same as for regular I/P stay for a limited number of days? 44/ 1- Days

d. Are benefits a specified sum of money? 47/ 1- Dollars

13. Coverage of Physician's Services:

Caesarean	52/	3,4 or 7-
"elective abortion"	57/	3,4 or 7-
Miscarriage	62/	3,4 or 7-

1. Same as regular surgery
2. Same as Normal Delivery
3. Special Maximum [enter $ amt]
4. Percent [enter amount]
5. None
6. Allowance included in Caesarean hospital allowance
7. Common Maximum: Hospital and Physician
8. Covered, but none of the above provisions apply.

GENERAL PROVISIONS

1. Are benefits provided for Home Health Care? 67/ 1-

MM Sched. No. of Scheds.
183

a. Are benefits provided for home visits by a registered nurse [RN]? 71/

b. Are benefits provided for home visits by a licensed practical nurse [LPN?] 72/

c. Are benefits provided for home visits by a certified home health aide? 73/

d. Are benefits provided for home visits by interns and residents in training under an approved teaching program of a hospital with which the home health care agency is affiliated? 74//

CARD 29

e. Are some days of prior hospitalization required? (1,2,3) — 13/ ☐ 1,3- ☐☐☐ Days

f. Are home health care visits limited to a specified number per week? — 17/ ☐ 1- ☐☐ Visits

g. Are home health care visits limited to a specified number per month? — 20/ ☐ 1- ☐☐☐ Visits

h. Are benefits provided for home visits for physical therapy? — 24/ ☐

i. Are Basic benefits provided for home visits for respiration or inhalation therapy? — 25/ ☐

		MM Sched.	No. of Scheds.
2. Are benefits provided for Supplies/Durable Equipment?	26// ☐ 1-	☐☐	☐ 184

INSTRUCTIONS FOR MAJOR MEDICAL SCHEDULES

Values for Major Medical Schedule

A. Benefit Provision-Indicate applicable number in leftmost box and amounts where called for.

If the upper range [To] is NO LIMIT, write 999998.

1. Sliding: Individual Level 1
2. Sliding: Individual Level 2
3. Sliding: Individual Level 3
4. Flat: Individual
5. Sliding: Family Level 1
6. Sliding: Family Level 2
7. Sliding: Family Level 3
8. Flat: Family

d. "Amount" in Benefit Provision was figured as follows:
   1. Total incurred cost is covered by MM where MM is a separate plan.
   2. Total incurred cost is covered by MM, when cost not covered by Basic is included in MM.
   3. Total incurred cost is covered by MM, after the deductible is met [MM only].
   4. Total incurred cost is covered by MM, after the deductible is met [MM and Basic].
   5. The total is paid by MM [could be MM alone or MM and Basic].
   6. Beneficiary's out-of-pocket payment [MM only].
   7. Beneficiary's out-of-pocket payment in excess of the deductible [MM only].
   8. Beneficiary's out-of-pocket payment [Basic & MM].
   9. Beneficiary's out-of-pocket payment in excess of the deductible [Basic & MM].

F. DEDUCTIBLE

2. How often does the deductible apply?
   1. Every a. [no.] days
   2. Every a. [no.] months
   3. Per disability
   4. Calendar year
   5. Per lifetime
   6. Per calendar year; accumulation period = ____ months

3. What is the carryover provision?
   1. a. [no.] days
   2. a. [no.] months
   3. NONE
   4. expenditure under one treatment plan

4. What is the family maximum?
   1. NONE
   2. A specified amount
   3. A specified no. of members meeting the deductible.

5. Is there an individual deductible?
   1. Yes
   2. No
   3. Yes, deductible based on salary to a maximum of $_____

G. SCHEDULE APPLIES TO:

1 = All
2 = Primary insured only
3 = Primary insured & children 18 or under, or full time students to age 22 only
4 = Dependent only
5 = Children 18 or under, or full time students to age 22 only
6 = Spouse only
7 = Primary insured & spouse only
8 = Primary insured and children only [definition of children different than 3 or undefined]
9 = Children only [definition of children different than 5 or undefined].

CARD 30

BOOKLET ID 19/ 3

MAJOR MEDICAL SCHEDULE - 1

A. BENEFIT PROVISION

	[1-8]	From:	To:	Payment is percent:	d.*
25/					
42/					
59//					

B. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

CARD 31

13/ [ ] [1 or 2]
2 3 4 5 6 7 8 9

C. MAXIMUM BENEFIT IS :

21/ [ ] (1-9) [ ] Amount Per [ ] [1-8] *

INTERNAL LIMIT - 2nd MAXIMUM

D. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

29/ [ ] [1 or 2]
2 3 4 5 6 7 8 9

E. MAXIMUM BENEFIT IS:

37/ [ ] (1-9) [ ] Amount Per [ ] [1-8] *

F. DEDUCTIBLE:

1. Is there a deductible? 45/ [ ] 2- Skip to H.
2. How Often? (1-6) 46/ [ ]
3. Carryover ? (1-4) 50/ [ ]
4. Family Amt.?[1-3] 54/ [ ]
5. Individual Deductible? (1-3) 59/ [ ]
6. Common to Schedules?

64/ [ ] (1 or 2)
2 3 4 5 6 7 8 9

*See Instructions for values

G. IS THERE A COMMON ACCIDENT DEDUCTIBLE? 72/ [ ] If 2, Skip

1. What is the common accident deductible? (1-3) 73/ [ ] 1 or 2 74// [ ]

   1 = a minimum specified number of members meeting the deductible
   2 = a specified amount.
   3 = none

CARD 32

2. The common accident deductible is satisfied when: 13/ [ ] (1-2)

   1 = one member meets the individual deductible
   2 = total expenses for all injured family members exceed the individual deductible amount

3. The common accident deductible applies: 14/ [ ] (1-3)

   1 = to all accident-related expenses only
   2 = to all covered expenses for injured family members
   3 = to all covered expenses for all family members

4. The common accident deductible satisfies the Major Medical deductible for: 15/ [ ] (1-

   1 = calendar year in which accident occurred
   2 = calendar year in which the accident occurred and the following year
   3 = Major Medical benefit period

H. SCHEDULE APPLIES TO: 16/ [ ] (1-

BOOKLET ID

MAJOR MEDICAL SCHEDULE - 2

BENEFIT PROVISION

[1-8] From: To: Payment is percent: d.*

MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

68// [1 or 2]

1 3 4 5 6 7 8 9

MAXIMUM BENEFIT IS :

ARD 33

(1-9) Amount Per [1-8] *

INTERNAL LIMIT - 2nd MAXIMUM

MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

21/ [1 or 2]

1 3 4 5 6 7 8 9

MAXIMUM BENEFIT IS:

(1-9) Amount Per [1-8] *

DEDUCTIBLE:

1. Is there a deductible? 37/ 2- Skip to H.
2. How Often? (1-6) 38/
3. Carryover ? (1-4) 42/
4. Family Amt.?[1-3] 46/
5. Individual Deductible? (1-3) 51/
6. Common to Schedules?

56/ (1 or 2)

1 3 4 5 6 7 8 9

*See Instructions for values

G. IS THERE A COMMON ACCIDENT DEDUCTIBLE? 64/ If 2, Skip to

1. What is the common accident deductible? (1-3) 65/ 1or2

   1 = a minimum specified number of members meeting the deductible
   2 = a specified amount.
   3 = none

   66/

2. The common accident deductible is satisfied when: 70/ (1-2)

   1 = one member meets the individual deductible
   2 = total expenses for all injured family members exceed the individual deductible amount

3. The common accident deductible applies: 71/ (1-3)

   1 = to all accident-related expenses only
   2 = to all covered expenses for injured family members
   3 = to all covered expenses for all family members

4. The common accident deductible satisfies the Major Medical deductible for: 72/ (1-3)

   1 = calendar year in which accident occurred
   2 = calendar year in which the accident occurred and the following year
   3 = Major Medical benefit period

H. SCHEDULE APPLIES TO: 73/ (1-9)

BOOKLET ID

MAJOR MEDICAL SCHEDULE- 3

BENEFIT PROVISION

CARD 34

[1-8] From: To: Payment is d.* percent:

13/

30/

47/

MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

64/ [1 or 2]

1 2 4 5 6 7 8 9

MAXIMUM BENEFIT IS :

21/ (1-3) Amount Per [1-8] *

INTERNAL LIMIT - 2nd MAXIMUM

CARD 35

MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

13/ [1 or 2]

1 2 4 5 6 7 8 9

MAXIMUM BENEFIT IS :

21/ (1-3) Amount Per [1-8] *

DEDUCTIBLE:

1. Is there a deductible? 29/ 2- Skip to H.
2. How Often? (1-4) 30/
3. Carryover ? (1-4) 34/
4. Family Amt.?[1-3] 38/
5. Individual Deductible? . (1-3) 43/
6. Common to Schedules?

48/ (1 or 2)

1 2 4 5 6 7 8 9

*See Instructions for values

G. IS THERE A COMMON ACCIDENT DEDUCTIBLE? 56/ If 2, Skip to

1. What is the common accident deductible? (1-3) 57/ 1or2

1 = a minimum specified number of members meeting the deductible
2 = a specified amount. 58/
3 = none

2. The common accident deductible is satisfied when: 62/ (1-2)

1 = one member meets the individual deductible
2 = total expenses for all injured family members exceed the individual deductible amount

3. The common accident deductible applies: 63/ (1-3)

1 = to all accident-related expenses only
2 = to all covered expenses for injured family members
3 = to all covered expenses for all family members

4. The common accident deductible satisfies the Major Medical deductible for: 64/ (1-3)

1 = calendar year in which accident occurred
2 = calendar year in which the accident occurred and the following year
3 = Major Medical benefit period

H. SCHEDULE APPLIES TO: 65// (1-9

BOOKLET ID

MAJOR MEDICAL SCHEDULE - 4

BENEFIT PROVISION

CARD 36

[1-3] From: To: Payment is d.* percent:

3/
0/
7/

. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

64/ [1 or 2]
1 2 3 5 6 7 8 9

. MAXIMUM BENEFIT IS :

2// (1-3) Amount Per [1-8] *

INTERNAL LIMIT - 2nd MAXIMUM

CARD 37

. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

13/ [1 or 2]
1 2 3 5 6 7 8 9

. MAXIMUM BENEFIT IS :

1/ (1-3) Amount Per [1-8] *

. DEDUCTIBLE:

1. Is there a deductible? 29/ 2- Skip to H.
2. How Often? (1-6) 30/
3. Carryover ? (1-4) 34/
4. Family Amt.?[1-3] 38/
5. Individual Deductible? (1-3) 43/
6. Common to Schedules?

48/ (1 or 2)
1 2 3 5 6 7 8 9

*See Instructions for values

G. IS THERE A COMMON ACCIDENT DEDUCTIBLE? 56/ If 2, Skip to

1. What is the common accident deductible? (1-3) 57/ 1or2

1 = a minimum specified number of members meeting the deductible
2 = a specified amount.
3 = none

58/

2. The common accident deductible is satisfied when: 62/ (1-2)

1 = one member meets the individual deductible
2 = total expenses for all injured family members exceed the individual deductible amount

3. The common accident deductible applies: 63/ (1-3)

1 = to all accident-related expenses only
2 = to all covered expenses for injured family members
3 = to all covered expenses for all family members

4. The common accident deductible satisfies the Major Medical deductible for: 64/ (1-3)

1 = calendar year in which accident occurred
2 = calendar year in which the accident occurred and the following year
3 = Major Medical benefit period

H. SCHEDULE APPLIES TO: 65/ (1-9)

BOOKLET ID

MAJOR MEDICAL SCHEDULE - 5

BENEFIT PROVISION

CARD 38

	[1-8]	From:	To:	Payment is percent:	d.*
13/					
10/					
17/					

C. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

64/ [1 or 2]

1 2 3 4 6 7 8 9

E. MAXIMUM BENEFIT IS :

12// (1-3) Amount Per [1-8] *

INTERNAL LIMIT - 2nd MAXIMUM

CARD 39

D. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

13/ [1 or 2]

1 2 3 4 6 7 8 9

E. MAXIMUM BENEFIT IS :

21/ (1-3) Amount Per [1-8] *

F. DEDUCTIBLE:

1. Is there a deductible? 29/ 2- Skip to H.
2. How Often? (1-6) 30/
3. Carryover ? (1-4) 34/
4. Family Amt.? [1-3] 38/
5. Individual Deductible? (1-3) 43/
6. Common to Schedules?

48/ (1 or 2)

1 2 3 4 6 7 8 9

*See Instructions for values

G. IS THERE A COMMON ACCIDENT DEDUCTIBLE? 56/ If 2, Skip

1. What is the common accident deductible? (1-3) 57/ 1or2-

   1 = a minimum specified number of members meeting the deductible
   2 = a specified amount. 58/
   3 = none

2. The common accident deductible is satisfied when: 62/ (1-2)

   1 = one member meets the individual deductible
   2 = total expenses for all injured family members exceed the individual deductible amount

3. The common accident deductible applies: 63/ (1-3)

   1 = to all accident-related expenses only
   2 = to all covered expenses for injured family members
   3 = to all covered expenses for all family members

4. The common accident deductible satisfies the Major Medical deductible for: 64/ (1-3)

   1 = calendar year in which accident occurred
   2 = calendar year in which the accident occurred and the following year
   3 = Major Medical benefit period

H. SCHEDULE APPLIES TO: 65// (1-9)

BOOKLET ID

MAJOR MEDICAL SCHEDULE - 6

BENEFIT PROVISION

ARD 40

(1-8)	From:	To:	Payment is percent:	d. *
3/				
0/				
7/				

MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

64/ [ ] [1 or 2]
1 2 3 4 5 7 8 9

MAXIMUM BENEFIT IS :

2/ [ ] (1-3) Amount [ ] Per [ ] [1-8] *

INTERNAL LIMIT - 2nd MAXIMUM

ARD 41

MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

13/ [ ] [1 or 2]
1 2 3 4 5 7 8 9

MAXIMUM BENEFIT IS:

1/ [ ] (1-3) Amount [ ] Per [ ] [1-8] *

DEDUCTIBLE:

1. Is there a deductible? 29/ [ ] 2- Skip to H.
2. How Often? (1-6) 30/
3. Carryover ?(1-4) 34/
4. Family Amt.?[1-3] 38/
5. Individual Deductible? (1-3) 43/
6. Common to Schedules?

48/ [ ] (1 or 2)
1 2 3 4 5 7 8 9

*See Instructions for values

G. IS THERE A COMMON ACCIDENT DEDUCTIBLE? 56/ [ ] If 2, Skip to H

1. What is the common accident deductible? (1-3) 57/ [ ] 1or2

   1 = a minimum specified number of members meeting the deductible
   2 = a specified amount.
   3 = none

   58/ [ ]

2. The common accident deductible is satisfied when: 62/ [ ] (1-2)

   1 = one member meets the individual deductible
   2 = total expenses for all injured family members exceed the individual deductible amount

3. The common accident deductible applies: 63/ [ ] (1-3)

   1 = to all accident-related expenses only
   2 = to all covered expenses for injured family members
   3 = to all covered expenses for all family members

4. The common accident deductible satisfies the Major Medical deductible for: 64/ [ ] (1-3)

   1 = calendar year in which accident occurred
   2 = calendar year in which the accident occurred and the following year
   3 = Major Medical benefit period

H. SCHEDULE APPLIES TO: 65/ [ ] (1-9)

BOOKLET ID

MAJOR MEDICAL SCHEDULE - 7

A. BENEFIT PROVISION

CARD 42

	[1-8] From:	To:	Payment is percent:	d.*
13/				
30/				
47/				

B. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

64/ [ ] [1 or 2]

1 2 3 4 5 6 8 9

C. MAXIMUM BENEFIT IS

72// [ ] (1-3) Amount [ ] Per

1 = year
2 = disability/condition
3 = lifetime
4 = day
5 = per 3 years

INTERNAL LIMIT - 2nd MAXIMUM

CARD 43

D. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

13/ [ ] [1 or 2]

1 2 3 4 5 6 8 9

E. MAXIMUM BENEFIT IS

21/ [ ] (1-3) Amount [ ] Per

1 = year
2 = disability/condition
3 = lifetime
4 = day
5 = per 3 years

F. DEDUCTIBLE:

1. Is there a deductible? 29/ [ ] 2- Skip to G
2. How Often? (1-6) 30/
3. Carryover ? (1-4) 34/
4. Family Amt.?[1-3] 38/
5. Individual Deductible? (1-3)43/
6. Common to Schedules?

48/ [ ] (1 or 2)

1 2 3 4 5 6 8 9

*See Instructions for values

G. IS THERE A COMMON ACCIDENT DEDUCTIBLE? 56/ [ ] If 2, Skip t

1. What is the common accident deductible? (1-3) 57/ [ ] 1or2-

1 = a minimum specified number of members meeting the deductible
2 = a specified amount.
3 = none

58/ [ ]

2. The common accident deductible is satisfied when: 62/ [ ] (1-2)

1 = one member meets the individual deductible
2 = total expenses for all injured family members exceed the individual deductible amount

3. The common accident deductible applies: 63/ [ ] (1-3)

1 = to all accident-related expenses only
2 = to all covered expenses for injured family members
3 = to all covered expenses for all family members

4. The common accident deductible satisfies the Major Medical deductible for: 64/ [ ] (1-3)

1 = calendar year in which accident occurred
2 = calendar year in which the accident occurred and the following year
3 = Major Medical benefit period

H. SCHEDULE APPLIES TO: 65// [ ] (1-9)

BOOKLET ID

MAJOR MEDICAL SCHEDULE - 8

BENEFIT PROVISION

CARD 44

[1-8] From: To: Payment is d.* percent:

/
/
/

MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

64/ [1 or 2]

1 2 3 4 5 6 7 9

MAXIMUM BENEFIT IS :

// (1-9) Amount Per [1-8] *

INTERNAL LIMIT - 2nd MAXIMUM

CARD 45

. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

13/ [1 or 2]

1 2 3 4 5 6 7 9

. MAXIMUM BENEFIT IS:

/ (1-9) Amount Per [1-8] *

. DEDUCTIBLE:

1. Is there a deductible? 29/ 2- Skip to H.
2. How Often? (1-6) 30/
3. Carryover ? (1-4) 34/
4. Family Amt.?[1-3] 38/
5. Individual Deductible? (1-3) 43/
6. Common to Schedules?

48/ (1 or 2)

1 2 3 4 5 6 7 9

*See Instructions for values

G. IS THERE A COMMON ACCIDENT DEDUCTIBLE? 56/ If 2, Skip to

1. What is the common accident deductible? (1-3) 57/ 1or2

   1 = a minimum specified number of members meeting the deductible
   2 = a specified amount. 58/
   3 = none

2. The common accident deductible is satisfied when: 62/ (1-2)

   1 = one member meets the individual deductible
   2 = total expenses for all injured family members exceed the individual deductible amount

3. The common accident deductible applies: 63/ (1-3)

   1 = to all accident-related expenses only
   2 = to all covered expenses for injured family members
   3 = to all covered expenses for all family members

4. The common accident deductible satisfies the Major Medical deductible for: 64/ (1-3)

   1 = calendar year in which accident occurred
   2 = calendar year in which the accident occurred and the following year
   3 = Major Medical benefit period

H. SCHEDULE APPLIES TO: 65// (1-9)

BOOKLET ID

MAJOR MEDICAL SCHEDULE - 9

A. BENEFIT PROVISION

CARD 45

	[1-8] From:	To:	Payment is percent:	d. *
13/				
30/				
47/				

B. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

64/ [ ] [1 or 2]
1 2 3 4 5 6 7 8

C. MAXIMUM BENEFIT IS :

72// [ ] (1-9) Amount [ ] Per [ ] [1-8] *

INTERNAL LIMIT - 2nd MAXIMUM

CARD 47

D. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

13/ [ ] [1 or 2]
1 2 3 4 5 6 7 8

E. MAXIMUM BENEFIT IS:

21/ [ ] (1-9) Amount [ ] Per [ ] [1-8] *

F. DEDUCTIBLE:

1.	Is there a deductible?	29/	2- Skip to H.
2.	How Often? (1-6)	30/	
3.	Carryover ? (1-4)	34/	
4.	Family Amt.?[1-3]	38/	
5.	Individual Deductible? (1-3)	43/	
6.	Common to Schedules?		

48/ [ ] (1 or 2)
1 2 3 4 5 6 7 8

*See Instructions for values

G. IS THERE A COMMON ACCIDENT DEDUCTIBLE? 56/ [ ] If 2, Skip

1. What is the common accident deductible? (1-3) 57/ [ ] 1 or 2

   1 = a minimum specified number of members meeting the deductible
   2 = a specified amount.
   3 = none

   58/ [ ]

2. The common accident deductible is satisfied when: 62/ [ ] (1-2)

   1 = one member meets the individual deductible
   2 = total expenses for all injured family members exceed the individual deductible amount

3. The common accident deductible applies: 63/ [ ] (1-3)

   1 = to all accident-related expenses only
   2 = to all covered expenses for injured family members
   3 = to all covered expenses for all family members

4. The common accident deductible satisfies the Major Medical deductible for: 64/ [ ] (1-3)

   1 = calendar year in which accident occurred
   2 = calendar year in which the accident occurred and the following year
   3 = Major Medical benefit period

H. SCHEDULE APPLIES TO: 65// [ ] (1-9)

CARD 51

CARRIER ID 13/ 5

BOOKLET ID 19/ 3

PRESCRIPTION DRUGS (OUTPATIENT)

A. 1. Are benefits provided for O/P prescription drugs? 25/

B. 1. Are benefits provided under a Major Medical Schedule? 26/ MM Sched. 1,3,4-

1. Yes, MM schedule only is coded.
2. No.
3. Yes, MM and question 2 coded
4. Yes, covered by Basic and MM

2. Plan Pays (Skip this question if B1. = 1) 29/ (1-5) a. b. c.

1. a.% of charge
2. $a. /prescription
3. Excess of $ a. /prescription
4. a.% in excess of $ b. per c. months
5. a.% of wholesale cost

3. Is there a maximum dollar amount per no. of months? 38/ 1- Mont

C. Are benefits provided for:

1. Any drug prescribed by a doctor? 45/

2. Drugs only obtainable by prescription (and no others)? 46/

3. Drugs only obtainable by prescription and a limited no. of over-the-counter drugs? 47/ (1-3)

1. Yes, contraceptives included.
2. No.
3. Yes, among prescription drugs, only contraceptives excluded.

4. Only some prescription drugs? 48/ (1-3)

1. Yes, contraceptives included.
2. No.
3. Yes, among prescription drugs, only contraceptives excluded.

D. Do any of the following restrictions apply?

1. Usual, customary and reasonable? 49/

2. Wholesale cost? 50/

3. Fee Schedule? 51/

4. Distinction made between member (participating) and non-member (non-participating) providers? 52/

E. 1. Does the plan have a coordination of benefits clause? 53/

2. Coordinates with which types of plan? (Write 1 or 2 in each box.)

P E G N 54/

P = Private
E = Employer
G = Group
N = No fault auto insur

F. Benefits apply to:

1 = All
2 = Primary insured only
3 = Primary insured and children 18 or under, or full time students to age 21-23 only
4 = Dependent only
5 = Children 18 or under, or full time students to age 21-23 only
6 = Spouse only
7 = Primary insured and spouse only
8 = Primary insured and children only (definition of children different than 3 or undefined).
9 = Children only (definition of children different than 5 or undefined)

58/ [ ] (1-9)

G. 1. All Eligibility Requirements:

1. the same as Basic?
2. the same as Major Medical?
3. different?

59// [ ] (1-3) If 3, complete Eligibility Schedule.

CARD 51

CARD 48

CARRIER ID 13/ 5

BOOKLET ID 19/ 3

DENTAL CARE

A. 1. Are benefits provided for dental treatment beyond emergency/accident or surgery related? (If yes, complete Col. A) 25/

2. Are benefits provided by a Major Medical Schedule? (If yes, complete A.1 if A=1. Note: Code any Dental Plan with deductibles or dollar maximums as Major Medical.] 26/ 1 - Go To A.4

3. Are benefits paid at a specified percent, other than 100%? [If yes - complete Column B if column A=1]. 27/

4. Is there a schedule of benefits? [If yes - complete column C if column A=1.] 28/ 2 or M - Go to QB

		A. Cov'd?	A.1 MM Sched.	B. Percent	C. $ Benefits
1.	Amalgam Filling [1 surface] permanent tooth	29/			
	a. primary tooth	38/			
2.	Prophylaxis - adult	47/			
	a. under 18	56/			
3.	Examination [periodic]-adult	65//			
	a. under 18	13/			
4.	Synthetic Filling [Acrylic/plastic]	22/			
5.	Bridge [3 units] [Add allowance for 2 crowns & 1 pontic of ceramco or porcelain to metal].	31/			
6.	Full Dentures [upper & lower]	40/			
7.	Full Mouth X-rays	49/			
8.	Root canal [2 roots]	58/			
9.	Porcelain Jacket Crown	67//			
10.	Subgingival Curettage [1 Quad]	13/			
11.	Extraction [simple]	22/			

CARD 49

CARD 50

CARD 48/49/50

B. Are dental benefits based on an incentive plan?

31/ ☐

C. 1. Are exams limited?

a. = No. of Exams b. = No. of months

32/ ☐ 1- a. ☐☐ Per b. ☐☐ Mths.

2. Is Prophylaxis limited?

a. = No. of prophy b. = No. of months

37/ ☐ 1- ☐☐ Per ☐☐ Mths.

D. Internal limits:

1. Usual, customary and reasonable.

2. None

42/ ☐ [1-2]

E. Is prior authorization required for: [exclude orthodontia]

1. All services?

2. Services in excess of $ a. [amount]?

3. Prosthodontia, crowns [non stainless steel] and inlays?

4. Specified services?

43/ ☐
44/ ☐ 1- a. ☐☐☐☐
49/ ☐
50/ ☐

F. Are benefits provided for Orthodontia?

51/ ☐

1. Is there a special maximum for orthodontia?

52/ ☐ 1- ☐☐☐☐ Per ☐ 1 = year 2 = lifetime 3 = conception/disability

2. Are benefits provided by a Major Medical Schedule?

58/ ☐ 1- ☐☐ MM Sched. If 1, Skip to G1.

3. Are benefits for basic plans coded on a General Benefit Schedule? If yes, enter number of schedules.

61/ ☐ 1- ☐ 185 No. of Scheds.

G. 1. Is there a waiting period for certain dental benefits?

63/ ☐

2. Is there a waiting period for prosthodontics? [If yes-indicate no. of months.]

64/ ☐ 1- ☐☐ Months

3. Is there a waiting period for orthodontics? [If yes-indicate no. of months.]

67/ ☐ 1- ☐☐ Months

4. Is there a waiting period for crowns? [If yes-indicate no. of months.]

70/ ☐ 1- ☐☐ Months

CARD 50

H. 1. Does the plan have a coordination of benefits clause? 73/ ☐

2. Coordinates with which types of plan?
[Write 1 or 2 in each box.]

	P	E	G	N
74/				

P = Private
E = Employer
G = Group
N = No fault auto insurance

I. Benefits apply to:

1 = All
2 = Primary insured only
3 = Primary insured & children 18 or under, or full time students to age 21-23 only
4 = Dependent only
5 = Children 18 or under, or full time students to age 21-23 only
6 = Spouse only
7 = Primary insured & spouse only
8 = Primary insured and children only (definition of children different than 3 or undefined).
9 = Children only (definition of children different than 5 or undefined)

78/ ☐ (1-9)

J. 1. Are Eligibility Requirements:

1. the same as Basic?
2. the same as Major Medical?
3. different?

79// ☐ (1-3) If 3, complete Eligibility Schedule.

CARD 50

CARD 52

CARRIER ID 13/ 5

BOOKLET ID 19/ 3

VISION CARE

A. 1. Are benefits provided for Vision Care? 25/

B. 1. Are benefits provided under a Major Medical Schedule? 26/ 1-

MM Sched.

2. Is there a common maximum for eye exams & glasses? 29/ 1-
[If yes- a.$ amount. per b. months.] a. b. Months

C. 1. Are benefits provided for Eye Exams? 35/
1. Yes, MM schedule only is coded. 2. No. 3. Yes, MM schedule and other limits coded below. 4. Yes, covered by Basic and MM. 5. Yes, Basic only.
1 - Go to C3
2 - Go to D

2. What is the eye exam benefit for an ophthalmologist? 36/ [1-5] a. b.
1. $ a. /exam
2. a.% /exam
3. a.% in excess of $b. /exam
4. a.% /year
5. None of the above

3. Are benefits different for an optometrist? 42/ [1-5] a. b.
[If yes- use the items in #2 to state benefits.]

4. Are the number of eye exams limited? 48/ 1-
(If yes-a. exams per b. months.]

D. 1. Are benefits provided for Lenses? 52/
1. Yes, MM schedule only is coded.
2. No
3. Yes, MM schedule and other limits coded below.
4. Yes, covered by Basic and MM 5. Yes, Basic only.
1 - Go to D3
2 - Go to E

2. What is the benefit for a pair of single/vision lenses? 53/ [1-2] a.
1. a.%
2. $a. /pair

3. Is the number of lenses limited? 57/ 1- Months
(If yes-a. pair per b. months.)

4. Are contact lenses covered:

a. unconditionally? 61/

b. only if medically necessary? 62/

c. in lieu of a pair of lenses with frames? 63/

d. in lieu of a pair of lenses? 64/

5. Are Shaded or Tinted Lenses covered:

a. unconditionally? 65/

b. only if medically necessary? 66/

CARD 52

E. 1. Are benefits provided for Frames?
1. Yes. MM schedule only is coded.
2. No
3. Yes. MM schedule and other limits coded below.
4. Yes, covered by Basic and MM
5. Yes, Basic only.

67/ [ ] 1 - Go to E3
2 - Go to F

2. What is the Frames benefit?
1. a.%b
2. $a.

a.
68/ [ ] [1-2] [ ]

3. Is the number of frames limited?
[If yes-a. frames per b. months.]

71// [ ] 1- [ ] Months

F. What further internal limits are there?

CARD 53

13/ [ ] [1-2]

1. Usual, customary and reasonable
2. None

G. 1. Does the plan have a coordination of benefits clause?

2. Coordinates with which types of plan?
[Write 1 or 2 in each box.]

14/ [ ] P E G N
15/ [ ] [ ] [ ] [ ]

P = Private
E = Employer
G = Group
N = No fault auto insurance

H. Benefits apply to:

19/ [ ] (1-9)

1 = All
2 = Primary insured only
3 = Primary insured & children 18 or under, or full time students to age 21-23 only
4 = Dependent only
5 = Children 18 or under, or full time students to age 21-23 only
6 = Spouse only
7 = Primary insured and spouse only
8 = Primary insured and children only (definition of children different than 3 or undefined).
9 = Children only (definition of children different than 5 or undefined)

J. 1. All Eligibility Requirements:

20// [ ] (1-3) If 3, complete Eligibility Schedule.

1. the same as Basic?
2. the same as Major Medical?
3. different?

CARD 54

CARRIER ID 13/ 5

BOOKLET ID 19/ 3

HEARING CARE

A. 1. Are benefits provided for hearing care? 25/ [ ] 2- Go to Next Section

B. 1. Are benefits provided under a Major Medical Schedule? 26/ [ ] 1- MM Sched [ ][ ]

2. Is there a common maximum for hearing exams and hearing aids/ [If yes.a. $ amt. per b. months]. 29/ [ ] 1- [ ][ ][ ][ ][ ] Months (a. b.)

C. 1. Are benefits provided for Hearing Exams?
1. Yes, MM schedule only is coded.
2. No.
3. Yes, MM schedule and other limits coded below.
4. Yes, covered by Basic and MM.
5. Yes. Basic only.

35/ [ ] 1 - Go to C3, 2 - Go to D

2. What is the hearing exam benefit? 36/ [ ] (1-6) [ ][ ][ ][ ][ ] (a. b.)
1. $ a. /exam
2. a.% /exam
3. a.% in excess of $ b. /exam
4. $ a. /months
5. $ a. [one time benefit]
6. None of the above.

3. Is the benefit different for an audiologist? 42/ [ ] (1-6) [ ][ ][ ][ ][ ] (a. b.)
[If yes-use the items in no. 2 to state benefit.]

4. Is the number of hearing exams limited? 48/ [ ] 1- [ ][ ][ ] Months
[If yes-a. exams per b. months.]

D. 1. Are benefits provided for Hearing Aids?
1. Yes, MM schedule only is coded.
2. No.
3. Yes, MM schedule and other limits coded below.
4. Yes, covered by Basic and MM. 5. Yes, Basic only.

52/ [ ] 1 - Go to D3, 2 - Go to E

2. What is the hearing aid benefit? 53/ [ ] [1-6] [ ][ ][ ][ ][ ] (a. b.)
1. $a./hearing aid.
2. a.%/hearing aid.
3. a.% in excess of $b./hearing aid
4. $a./months
5. $a.- [one time benefit]
6. None of the above.

3. Is the number of hearing aids limited? 59/ [ ] 1- [ ][ ][ ] (a. b.)
[If yes-a. aids per b. months].

E. 1. Is the physician's exam required before eligible for hearing aids? 63/ [ ]

2. What further limits are there? 64/ [ ] [1-2]
1. Usual, customary and reasonable
2. None

F. 1. Does the plan have a coordination of benefits clause? 65/ [ ] P E G N

2. Coordinates with which types of plan? 66/ [ ][ ][ ][ ]
[Write 1 or 2 in each box.]

P = Private
E = Employer
G = Group
N = No fault auto insurance

G. Benefits apply to:

1 = All
2 = Primary insured only
3 = Primary insured and children 18 or under, or full time students to age 21-23 only
4 = Dependent only
5 = Children 18 or under, or full time students to age 21-23 only
6 = Spouse only
7 = Primary insured and spouse only
8 = Primary insured and children only (definition of children different than 3 or undefined).
9 = Children only (definition of children different than 5 or undefined)

70/ [ ] (1-9)

H. 1. All Eligibility Requirements:

1. the same as Basic?
2. the same as Major Medical?
3. different?

71// [ ] (1-3) If 3, complete Eligibility Schedule.

CARD 54

CARD 55

CARRIER ID 13/ 5

BOOKLET ID 19/ 3

HOSPITAL INDEMNITY QUESTIONNAIRE

A. Are hospital indemnity benefits provided? 25/

B. Is there a maximum dollar amount per disability? 26/ 1 - Dollars

C. Is there a maximum dollar amount per lifetime? 33/ 1 - Dollars

D. Number of Payment Schedules: 40/ [1-3]

41/ 52/ 63/ 1 = Days 2 = weeks From To Benefit is 1 = Daily 2 = Weekly

E. Are children's benefits reduced by a percentage of the adults? 74// 1 - %

F. Does the hospital indemnity:

CARD 56

1. Pay only for specified dread disease? 13/
2. Pay only for cancer? 14/
3. Pay for mental disorders? 15/ (1,2,3)
   1 = Yes 2 = No 3 = Yes, covered but benefits differ from QD.
4. Pay for pregnancy? 16/ (1,2,3)
   1 = Yes 2 = No 3 = Yes, covered but benefits differ from QD.
5. Pay for other disabilities? 17/

G. Are Eligibility Requirements different from those for Basic Coverage? 18/ 1- Complete Eligibility Schedule

H. 1. Does the plan have a coordination of benefits clause? 19/ P E G N

   2. Coordinates with which types of plan? [Write 1 or 2 in each box.] 20/

P = Private
E = Employer
G = Group
N = No fault auto insurance

CARD 55/56

1. Benefits apply to:

24//[ ] (1-9)

1 = All
2 = Primary insured only
3 = Primary insured and children 18 or under, or full time students to age 21-23 only
4 = Dependent only
5 = Children 18 or under, or full time students to age 21-23 only
6 = Spouse only
7 = Primary insured and spouse only
8 = Primary insured and children only (definition of children different than 3 or undefined).
9 = Children only (definition of children different than 5 or undefined)

CARD 57

CARRIER ID 13/ 5

BOOKLET ID 19/ 3

PROLONGED ILLNESS

1. Does the policy/booklet provide prolonged illness coverage? 25/

2. Indicate with "1" [yes] which of the following are considered prolonged illness conditions:

(1 or 2)

a. Cancer 26/

b. Severe burns 27/

c. Paralysis caused by: brain or spinal tumors, Polio, and Multiple Sclerosis 28/

d. Brain hemorrhage 29/

e. Addison's disease, pituitary disorders, or other major endocrine diseases, but not including diabetes 30/

f. Coronary or cerebral thrombosis 31/

g. Disabling major bone fractures, bone fusions, joint dislocations joint fusions, and limb amputations 32/

h. Active Tuberculosis 33/

i. Cystic Fibrosis 34/

j. Muscular Dystrophy 35/

k. Chronic osteomyelitis 36/

l. Chronic congestive heart failure 37/

m. Chronic rheumatic fever 38/

n. Chronic rheumatoid arthritis, lupus erythematosus, and other chronic collagen or systemic sensitivity 39/

o. Chronic nephrosis, nephritis 40/

p. Chronic hemolytic, aplastic or toxic anemia 41/

q. Chronic bleeding disorders requiring continuing therapy [not including iron deficiency or blood loss anemia] 42/

r. Acute infarction of the heart 43/

s. Chronic ulcerative colitis and chronic regional enteritis 44/

CARD 57

3. Indicate the appropriate PIC schedule for the following medical expenses when applicable: [1, 2, 3 or M]

a.	Hospital Room and Board	45/	
b.	Hospital Miscellaneous	46/	
c.	ECF	47/	
d.	Hospital Outpatient	48/	
e.	Physician's OP Visits	49/	
f.	Surgery	50/	
g.	Anesthesia	51/	
h.	Ambulance	52/	
i.	OP X-ray Lab	53/	
j.	Home Health Care	54/	
K.	Supplies/Durable Equipment	55/	
l.	Prescription Drugs	56/	

CARD 57

PROLONGED ILLNESS SCHEDULE-1

A. BENEFIT PROVISION

(1-8) From: To: Payment is percent: d.*

57// CARD 58
13/
30/

B. MAXIMUM BENEFIT IS COMMON TO SCHEDULE: pic pic

47/ (1 or 2)
1 2 3 4 5 6 7 8 9 2 3

C. MAXIMUM BENEFIT IS

58/ (1-3) Amount Per

1 = year
2 = disability/condition
3 = lifetime
4 = day
5 = per 3 years

INTERNAL LIMIT - 2nd MAXIMUM

D. MAXIMUM BENEFIT IS COMMON TO SCHEDULE: pic pic

66// (1 or 2)
1 2 3 4 5 6 7 8 9 2 3

E. MAXIMUM BENEFITS IS

CARD 59

13/ (1-3) Amount Per

1 = year
2 = disability/condition
3 = lifetime
4 = day
5 = per 3 years

F. DEDUCTIBLE

1. Is there a deductible? 21/ 2 - Skip to G
2. How Often? (1-3) 22/
3. Carryover? (1-4) 26/
4. Family Amt.? (1-3) 30/
5. Individual Deductible? (1-3) 35/
6. Common to Schedules? (1,2)

pic pic

40/
1 2 3 4 5 6 7 8 9 2 3

G. SCHEDULE APPLIES TO:* 51/ (1-9)

*See Instructions for values

CARD 57/58/59

PROLONGED ILLNESS SCHEDULE - 2

A. BENEFIT PROVISION

	(1-8)	From:	To:	Payment is percent:	d.*
37/					
CARD 60 13/					
30/					

B. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

47/ [ ] (1 or 2)

pic pic
1 2 3 4 5 6 7 8 9 1 3

C. MAXIMUM BENEFIT IS

58/ [ ] (1-8) [ ] Amount Per [ ]

1 = year
2 = disability/condition
3 = lifetime
4 = day
5 = per 3 years

INTERNAL LIMIT - 2nd MAXIMUM

D. MAXIMUM BENEFIT IS COMMON TO SCHEDULE:

66// [ ] (1 or 2)

pic pic
1 2 3 4 5 6 7 8 9 1 3

E. MAXIMUM BENEFITS IS

CARD 61 13/ [ ] (1-8) [ ] Amount Per [ ]

1 = year
2 = disability/condition
3 = lifetime
4 = day
5 = per 3 years

F. DEDUCTIBLE

1. Is there a deductible? 21/ [ ] 2 - Skip to G
2. How Often? (1-8) 22/
3. Carryover? (1-4) 26/
4. Family Amt.? (1-3) 30/
5. Individual Deductible? (1-3) 35/
6. Common to Schedules? (1,2)

40/

pic pic
1 2 3 4 5 6 7 8 9 1 3

G. SCHEDULE APPLIES TO:* 51/ [ ] (1-3)

*See Instructions for values

PROLONGED ILLNESS SCHEDULE - 3

A. BENEFIT PROVISION

(1-8) From: To: Payment is percent: d.*

CARD 62

57//
13/
30/

B. MAXIMUM BENEFIT IS COMMON TO SCHEDULE: pic pic

47/ (1 or 2)

1 2 3 4 5 6 7 8 9 1 2

C. MAXIMUM BENEFIT IS

58/ (1-3) Amount Per

1 = year
2 = disability/condition
3 = lifetime
4 = day
5 = per 3 years

INTERNAL LIMIT - 2nd MAXIMUM

D. MAXIMUM BENEFIT IS COMMON TO SCHEDULE: pic pic

66// (1 or 2)

1 2 3 4 5 6 7 8 9 1 2

E. MAXIMUM BENEFITS IS

CARD 63

13/ (1-3) Amount Per

1 = year
2 = disability/condition
3 = lifetime
4 = day
5 = per 3 years

F. DEDUCTIBLE

1. Is there a deductible? 21/ 2 - Skip to G
2. How Often? (1-8) 22/
3. Carryover? (1-4) 26/
4. Family Amt.? (1-3) 30/
5. Individual Deductible? (1-8) 35/
6. Common to Schedules? (1,2)

40/ pic pic

1 2 3 4 5 6 7 8 9 1 2

G. SCHEDULE APPLIES TO:* 51/ (1-9)

*See Instructions for values

FOR

HEALTH INSURANCE ABSTRACTION
INSTRUCTIONS FOR THE GENERAL BENEFITS SCHEDULE

1. PROCEDURE NO.- The box number indicated on the coverage questionnaire.

2. APPLIES TO-Indicates to whom the coverage applies [i.e. primary insured and/or dependents].

1 = All
2 = Primary insured only
3 = Primary insured & children 18 or under, or full time students to age 22 only
4 = Dependent only
5 = Children 18 or under, or full time students to age 22 only
6 = Spouse only
7 = Primary insured & spouse only
8 = Primary insured and children only [definition of children different than 3 or undefined]
9 = Children only [definition of children different than 5 or undefined].

3. SCHEDULE NO.-Provides for three sets of benefits if changes occur through time periods.

4. BENEFIT PERIOD SCOPE-Indicates the limits of coverage. This is expressed as the minimum and/or maximum amount, quantity or number provided for the health service.

01 = No limit
03 = Range: Days from [quantity] to [quantity]
04 = Range: Visits from [quantity] to [quantity]
05 = Range: Dollars from $ [amount] to $ [amount]
06 = Range: Days from [quantity] to No Limit
07 = Range: Visits from [quantity] to No Limit
08 = Range: Dollars from $ [amount] to No Limit
09 = Per Confinement
10 = Per Calendar Year
11 = Per Disability
90 = (see below) 91 = (see below)

5. BENEFIT PROVISION-Indicates the sum available for the specific health service.

12 = Maximum: Lifetime a. _____
30 = Money: $[amount] for each year
31 = Money: $[amount] for each day
32 = Money: $[amount] for each illness/disability
33 = Money: $[amount] for each injury
34 = Money: $[amount] for each surgery
35 = Money: $[amount] for each trip
36 = Money: $[amount] for each hospitalization
37 = Money: $[amount] per [months]
38 = Money: $[amount] per [months of illness]
39 = Money: $[amount] for each visit
41 = Excess of $[amount] per day
42 = Excess of $[amount] per visit
44 = Ward
45 = Ward plus $[amount] additional
46 = Ward plus [percent]% of additional
47 = Rate: [number] X Room and Board Allowance
48 = Percent: [number]% of the total cost
49 = Percent: [number]% of the cost for each day or visit
50 = Percent: [number]% of fee schedule/allowance
51 = Percent: [number]% of the cost for each illness
52 = Percent: [number]% of the cost of each injury
53 = Percent: [number]% of the cost of each surgery
54 = Percent: [number]% of the cost of each trip
55 = Percent: [number]% per hospitalization
56 = Percent: [number]% per [months]
57 = Percent: [number]% [months] of illness
58 = Percent: [number]% of the Room and Board allowance
59 = Combination: $[amount] plus [percent]% of Balance
60 = Combination: $[amount] plus [percent]% per trip
61 = Combination: $[amount] plus [percent]% per illness
62 = Combination: $[amount] plus [percent]% per [months]
63 = Combination: [percent]% up to $[amount] per [months]
64 = Semi-private [two beds]
65 = Semi-private plus $[amount] additional
66 = Semi-private plus [percent]% of additional
67 = Money: $[amount] for all illnesses or each injury
69 = Medicare reasonable & customary
79 = Shares provisions shown in level a._____ on mm schedule[s] b._____ c._____
82 = Maximum in common with procedure no[s] a.____ b.____ c.____
90 = Benefit period/scope and benefit provisions inapplicable. Coded in previous GBS.
91 = Benefit period/scope and benefit provisions inapplicable. Coded in MM Sched. a. _____

move to Benefit Per. Scope

6. ADDITIONAL LIMITS - Indicates further qualifications or conditions placed on the benefit coverage.

13 = Maximum: Room and Board
14 = Maximum: Inpatient Miscellaneous
15 = Maximum: Physician's Inpatient
16 = Maximum: Physician's Outpatient
17 = Maximum: Common Maternity
18 = Maximum: All psychiatric
19 = Maximum: Outpatient Psychiatric
20 = Maximum: Inpatient Psychiatric
21 = Subject to Deductible of $[Amount]
26 = Room and Board expiration
71 = Surgery Fee Schedule
72 = Per surgery per [months] or return to work
73 = Fee Schedule/RVS Schedule
82 = (see above)

[01 - 11] As above in Benefit Period Scope
[12, 30-73] As above in Benefit Provision

nly [BENEFIT PERIOD LIMITS [1-6]

1. Per Condition/Disability
2. Per Year
3. Per Condition Per Year
4. No limits on year or condition
6. Per confinement

1/ SDP#

11/ CARD 01

13/ HIEI: 4 3 3

CARRIER ID 16/ 5

BOOKLET ID 22/ 3

DATE CODED: 28/ Mon. Day Year

HEALTH INSURANCE ABSTRACTION

GENERAL BENEFITS SCHEDULE

1. Procedure No. 36/ 2. Applies to 3. Schedule No.

4. Benefit Period 41/ a. b. c.

5. Benefit Provisions 55// a. b. c.

CARD 02

6. Additional Limits 13/ a. b. c.

---

1. Procedure No. 33/ 2. Applies to 3. Schedule No.

4. Benefit Period 38/ a. b. c.

5. Benefit Provisions 52// a. b. c.

CARD 03

6. Additional Limits 13/ a. b. c.

---

1. Procedure No. 33/ 2. Applies to 3. Schedule No.

4. Benefit Period 38/ a. b. c.

5. Benefit Provisions 52// a. b. c.

CARD 04

6. Additional Limits 13/ a. b. c.

---

1. Procedure No. 33/ 2. Applies to 3. Schedule No.

4. Benefit Period 38/ a. b. c.

5. Benefit Provisions 52// a. b. c.

CARD 05

6. Additional Limits 13/ a. b. c.

REFERENCES

Brook, Robert H., John E. Ware, Jr., William H. Rogers, Emmett B. Keeler, Allyson R. Davies, Cathy A. Sherbourne, George A. Goldberg, Kathleen N. Lohr, Patricia Camp, and Joseph P. Newhouse, *The Effect of Coinsurance on the Health of Adults,* The RAND Corporation, R-3055-HHS, 1984.

Cook, R. D., "Detection of Influential Observations in Linear Regression," *Technometrics,* Vol. 19, 1977, pp. 15-19.

Farley, Pamela J., "Who Are the Uninsured?" *Milbank Memorial Fund Quarterly, Health and Society,* Vol. 63, No. 3, Summer 1985, pp. 476-503.

Francis, Walton, *Checkbook's Guide to 1984 Health Insurance Plans for Federal Employees,* Center for the Study of Services, Washington, D.C., 1983.

Kasper, Judith A., Daniel C. Walden, Gail R. Wilensky, "Who Are the Uninsured?" Department of Health and Human Services National Health Care Expenditures Study, Data Preview 1, 1980.

Kunreuther, Howard, "Limited Knowledge and Insurance Protection," *Public Policy,* Vol. 24, No. 2, Spring 1976, pp. 227-261.

Marquis, M. Susan, "Consumers' Knowledge About Their Health Insurance Coverage," *Health Care Financing Review,* Vol. 5, No. 1, Fall 1983, pp. 65-80.

Monheit, Alan C., Michael M. Hagan, Marc L. Berk, Pamela J. Farley, "The Employed Uninsured and the Role of Public Policy," *Inquiry,* Volume XXII, No. 4, Winter 1985, pp. 348-364.

Newhouse, Joseph P., Charles E. Phelps, and M. Susan Marquis, "On Having Your Cake and Eating it Too," *Journal of Econometrics,* Vol. 13, 1980, pp. 365-390.

Newhouse, Joseph P., Willard G. Manning, Carl N. Morris, Larry L. Orr, Naihua Duan, Emett B. Keeler, Arleen Leibowitz, Kent H. Marquis, M. Susan Marquis, Charles E. Phelps, Robert H. Brook, *Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance,* The RAND Corporation, R-2847-HHS, 1982.

Wilensky, Gail R., Pamela J. Farley, and Amy K. Taylor, "Variations in Health Insurance Coverage: Benefits vs. Premiums," *Milbank Memorial Fund Quarterly, Health and Society,* Vol. 62, No. 1, 1984, pp. 53-81.

RAND/N-2503-HHS